Senate Bill No. 2077

CHAPTER 820

An act to amend Sections 1770, 1771, 1771.2, 1772, 1773, 1774, 1775, 1776.6, 1777, 1777.2, 1777.4, 1779, 1779.2, 1779.4, 1779.6, 1779.8, 1779.10, 1780, 1780.2, 1780.4, 1781, 1781.2, 1781.4, 1781.6, 1781.8, 1781.10, 1782, 1783, 1783.2, 1784, 1785, 1786, 1786.2, 1787, 1788, 1788.2, 1788.4, 1789, 1789.2, 1789.4, 1789.6, 1789.8, 1793.5, 1793.6, 1793.7, 1793.8, 1793.9, 1793.11, 1793.13, 1793.15, 1793.17, 1793.19, 1793.21, 1793.23, 1793.25, 1793.27, 1793.29, 1793.50, 1793.56, 1793.58, 1793.60, and 1793.62 of, to amend and renumber Sections 1771.9 and 1771.11 of, to add Sections 1771.3, 1772.2, 1779.7, 1783.3, 1789.1, 1792.1, 1792.3, 1792.4, 1792.5, and 1792.6 to, to add Article 6.5 (commencing with Section 1792.11) of Chapter 10 of Division 2 of, to repeal Section 1771.8 of, and to repeal and add Sections 1771.4, 1771.5, 1771.6, 1771.7, 1792, and 1792.2 of, the Health and Safety Code, relating to continuing care contracts, and making an appropriation therefor.

[Approved by Governor September 28, 2000. Filed with Secretary of State September 28, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

SB 2077, Ortiz. Continuing care contracts: retirement communities: elderly.

Existing law contains provisions relating to supervision of life care contracts, also known as continuing care contracts, including requirements governing continuing care communities and contracts.

This bill would revise and recast these provisions, including changes to the definitions used in these provisions, rights of continuing care community residents, requirements for the obtaining of a certificate of authority for a continuing care community, and continuing care contract requirements.

Existing law creates the Continuing Care Provider Fee Fund, which is continuously appropriated to the State Department of Social Services for purposes of administering continuing care retirement community provisions. The fund consists of fees paid to the department pursuant to these provisions.

This bill would make various changes in provisions relating to the establishment of fees, including requirements pertaining to the establishment of fees for changes in continuing care provider organizations, thus increasing payments to the fund and thereby constituting an appropriation.

This bill would also establish liquid reserve requirements that providers shall be required to meet, and would authorize the department to increase liquid reserve requirements in certain

circumstances. The bill would establish refund reserve requirements for certain providers.

This bill would, until January 1, 2005, establish requirements for the department to implement a trial program, and report to the Legislature, on assessing long-term care provider solvency. The trial program would require each provider to obtain an actuarial study and file it with the department, except under specified circumstances.

Existing continuing care provisions specify that any entity that sells deposit subscriptions that either proposes to promise to provide care without having a current and valid permit to sell these subscriptions or fails to place any consideration into an escrow account is guilty of a misdemeanor.

This bill would provide that these misdemeanors relate to any entity that accepts deposits, rather than any entity that sells deposit subscriptions.

Because the bill would change the definition of a crime, it would constitute a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1770 of the Health and Safety Code is amended to read:

1770. The Legislature finds, declares, and intends all of the following:

(a) Continuing care retirement communities are an alternative for the long-term residential, social, and health care needs of California's elderly residents and seek to provide a continuum of care, minimize transfer trauma, and allow services to be provided in an appropriately licensed setting.

(b) Because elderly residents often both expend a significant portion of their savings in order to purchase care in a continuing care retirement community and expect to receive care at their continuing care retirement community for the rest of their lives, tragic consequences can result if a continuing care provider becomes insolvent or unable to provide responsible care.

(c) There is a need for disclosure concerning the terms of agreements made between prospective residents and the continuing care provider, and concerning the operations of the continuing care retirement community.

(d) Providers of continuing care should be required to obtain a certificate of authority to enter into continuing care contracts and should be monitored and regulated by the State Department of Social Services.

(e) This chapter applies equally to for-profit and nonprofit provider entities.

(f) This chapter states the minimum requirements to be imposed upon any entity offering or providing continuing care.

(g) Because the authority to enter into continuing care contracts granted by the State Department of Social Services is neither a guarantee of performance by the providers nor an endorsement of any continuing care contract provisions, prospective residents must carefully consider the risks, benefits, and costs before signing a continuing care contract and should be encouraged to seek financial and legal advice before doing so.

SEC. 2. Section 1771 of the Health and Safety Code is amended to read:

1771. Unless the context otherwise requires, the definitions in this section govern the interpretation of this chapter.

(a) (1) ''Affiliate'' means any person, corporation, limited liability company, business trust, trust, partnership, unincorporated association, or other legal entity that directly or indirectly controls, is controlled by, or is under common control with, a provider or applicant.

(2) ''Affinity group'' means a grouping of entities sharing a common interest, philosophy, or connection (e.g., military officers, religion).

(3) ''Annual report'' means the report each provider is required to file annually with the department, as described in Section 1790.

(4) ''Applicant'' means any entity, or combination of entities, that submits and has pending an application to the department for a permit to accept deposits and a certificate of authority.

(5) ''Assisted living services'' includes, but is not limited to, assistance with personal activities of daily living, including dressing, feeding, toileting, bathing, grooming, mobility, and associated tasks, to help provide for and maintain physical and psychosocial comfort.

(6) ''Assisted living unit'' means the living area or unit within a continuing care retirement community that is specifically designed to provide ongoing assisted living services.

(7) ''Audited financial statement'' means financial statements prepared in accordance with generally accepted accounting principles including the opinion of an independent certified public accountant, and notes to the financial statements considered customary or necessary to provide full disclosure and complete information regarding the provider's financial statements, financial condition, and operation.

(b) (reserved)

(c) (1) ‘‘Cancel’’ means to destroy the force and effect of an agreement or continuing care contract.

(2) ‘‘Cancellation period’’ means the 90-day period, beginning when the resident physically moves into the continuing care retirement community, during which the resident may cancel the continuing care contract, as provided in Section 1788.2.

(3) ‘‘Care’’ means nursing, medical, or other health related services, protection or supervision, assistance with the personal activities of daily living, or any combination of those services.

(4) ‘‘Cash equivalent’’ means certificates of deposit and United States treasury securities with a maturity of five years or less.

(5) ‘‘Certificate’’ or ‘‘certificate of authority’’ means the certificate issued by the department, properly executed and bearing the State Seal, authorizing a specified provider to enter into one or more continuing care contracts at a single specified continuing care retirement community.

(6) ‘‘Condition’’ means a restriction, specific action, or other requirement imposed by the department for the initial or continuing validity of a permit to accept deposits, a provisional certificate of authority, or a certificate of authority. A condition may limit the circumstances under which the provider may enter into any new deposit agreement or contract, or may be imposed as a condition precedent to the issuance of a permit to accept deposits, a provisional certificate of authority, or a certificate of authority.

(7) ‘‘Consideration’’ means some right, interest, profit, or benefit paid, transferred, promised, or provided by one party to another as an inducement to contract. Consideration includes some forbearance, detriment, loss, or responsibility, that is given, suffered, or undertaken by a party as an inducement to another party to contract.

(8) ‘‘Continuing care contract’’ means a contract that includes a continuing care promise made, in exchange for an entrance fee, the payment of periodic charges, or both types of payments. A continuing care contract may consist of one agreement or a series of agreements and other writings incorporated by reference.

(9) ‘‘Continuing care advisory committee’’ means an advisory panel appointed pursuant to Section 1777.

(10) ‘‘Continuing care promise’’ means a promise, expressed or implied, by a provider to provide one or more elements of care to an elderly resident for the duration of his or her life or for a term in excess of one year. Any such promise or representation, whether part of a continuing care contract, other agreement, or series of agreements, or contained in any advertisement, brochure, or other material, either written or oral, is a continuing care promise.

(11) ‘‘Continuing care retirement community’’ means a facility located within the State of California where services promised in a continuing care contract are provided. A distinct phase of

development approved by the department may be considered to be the continuing care retirement community when a project is being developed in successive distinct phases over a period of time. When the services are provided in residents' own homes, the homes into which the provider takes those services are considered part of the continuing care retirement community.

(12) ''Control'' means directing or causing the direction of the financial management or the policies of another entity, including an operator of a continuing care retirement community, whether by means of the controlling entity's ownership interest, contract, or any other involvement. A parent entity or sole member of an entity controls a subsidiary entity provider for a continuing care retirement community if its officers, directors, or agents directly participate in the management of the subsidiary entity or in the initiation or approval of policies that affect the continuing care retirement community's operations, including, but not limited to, approving budgets or the administrator for a continuing care retirement community.

(d) (1) ''Department'' means the State Department of Social Services.

(2) ''Deposit'' means any transfer of consideration, including a promise to transfer money or property, made by a depositor to any entity that promises or proposes to promise to provide continuing care, but is not authorized to enter into a continuing care contract with the potential depositor.

(3) ''Deposit agreement'' means any agreement made between any entity accepting a deposit and a depositor. Deposit agreements for deposits received by an applicant prior to the department's release of funds from the deposit escrow account shall be subject to the requirements described in Section 1780.4.

(4) ''Depository'' means a bank or institution that is a member of the Federal Deposit Insurance Corporation or a comparable deposit insurance program.

(5) ''Depositor'' means any prospective resident who pays a deposit. Where any portion of the consideration transferred to an applicant as a deposit or to a provider as consideration for a continuing care contract is transferred by a person other than the prospective resident or a resident, that third-party transferor shall have the same cancellation or refund rights as the prospective resident or resident for whose benefit the consideration was transferred.

(6) ''Director'' means the Director of Social Services.

(e) (1) ''Elderly'' means an individual who is 60 years of age or older.

(2) ''Entity'' means an individual, partnership, corporation, limited liability company, and any other form for doing business.

Entity includes a person, sole proprietorship, estate, trust, association, and joint venture.

(3) ‘‘Entrance fee’’ means the sum of any initial, amortized, or deferred transfer of consideration made or promised to be made by, or on behalf of, a person entering into a continuing care contract for the purpose of assuring care or related services pursuant to that continuing care contract or as full or partial payment for the promise to provide care for the term of the continuing care contract. Entrance fee includes the purchase price of a condominium, cooperative, or other interest sold in connection with a promise of continuing care. An initial, amortized, or deferred transfer of consideration that is greater in value than 12 times the monthly care fee shall be presumed to be an entrance fee.

(4) ‘‘Equity’’ means the value of real property in excess of the aggregate amount of all liabilities secured by the property.

(5) ‘‘Equity interest’’ means an interest held by a resident in a continuing care retirement community that consists of either an ownership interest in any part of the continuing care retirement community property or a transferable membership that entitles the holder to reside at the continuing care retirement community.

(6) ‘‘Equity project’’ means a continuing care retirement community where residents receive an equity interest in the continuing care retirement community property.

(7) ‘‘Equity securities’’ shall refer generally to large and midcapitalization corporate stocks that are publicly traded and readily liquidated for cash, and shall include shares in mutual funds that hold portfolios consisting predominantly of these stocks and other qualifying assets, as defined by Section 1792.2. Equity securities shall also include other similar securities that are specifically approved by the department.

(8) ‘‘Escrow agent’’ means a bank or institution, including, but not limited to, a title insurance company, approved by the department to hold and render accountings for deposits of cash or cash equivalents.

(f) ‘‘Facility’’ means any place or accommodation where a provider provides or will provide a resident with care or related services, whether or not the place or accommodation is constructed, owned, leased, rented, or otherwise contracted for by the provider.

(g) (reserved)

(h) (reserved)

(i) (1) ‘‘Inactive certificate of authority’’ means a certificate that has been terminated under Section 1793.8.

(2) ‘‘Investment securities’’ means any of the following:

(A) Direct obligations of the United States, including obligations issued or held in book-entry form on the books of the United States Department of the Treasury or obligations the timely payment of the

principal of, and the interest on, which are fully guaranteed by the United States.

(B) Obligations, debentures, notes, or other evidences of indebtedness issued or guaranteed by any of the following:

(i) The Federal Home Loan Bank System.

(ii) The Export-Import Bank of the United States.

(iii) The Federal Financing Bank.

(iv) The Government National Mortgage Association.

(v) The Farmer's Home Administration.

(vi) The Federal Home Loan Mortgage Corporation of the Federal Housing Administration.

(vii) Any agency, department, or other instrumentality of the United States if the obligations are rated in one of the two highest rating categories of each rating agency rating those obligations.

(C) Bonds of the State of California or of any county, city and county, or city in this state, if rated in one of the two highest rating categories of each rating agency rating those bonds.

(D) Commercial paper of finance companies and banking institutions rated in one of the two highest categories of each rating agency rating those instruments.

(E) Repurchase agreements fully secured by collateral security described in subparagraph (A) or (B), as evidenced by an opinion of counsel, if the collateral is held by the provider or a third party during the term of the repurchase agreement, pursuant to the terms of the agreement, subject to liens or claims of third parties, and has a market value, which is determined at least every 14 days, at least equal to the amount so invested.

(F) Long-term investment agreements, which have maturity dates in excess of one year, with financial institutions, including, but not limited to, banks and insurance companies or their affiliates, if the financial institution's paying ability for debt obligations or long-term claims or the paying ability of a related guarantor of the financial institution for these obligations or claims, is rated in one of the two highest rating categories of each rating agency rating those instruments, or if the short-term investment agreements are with the financial institution or the related guarantor of the financial institution, the long-term or short-term debt obligations, whichever is applicable, of which are rated in one of the two highest long-term or short-term rating categories, of each rating agency rating the bonds of the financial institution or the related guarantor, provided that if the rating falls below the two highest rating categories, the investment agreement shall allow the provider the option to replace the financial institution or the related guarantor of the financial institution or shall provide for the investment securities to be fully collateralized by investments described in subparagraph (A), and, provided further, if so collateralized, that the provider has a

perfected first security lien on the collateral, as evidenced by an opinion of counsel and the collateral is held by the provider.

(G) Banker's acceptances or certificates of deposit of, or time deposits in, any savings and loan association that meets any of the following criteria:

(i) The debt obligations of the savings and loan association, or in the case of a principal bank, of the bank holding company, are rated in one of the two highest rating categories of each rating agency rating those instruments.

(ii) The certificates of deposit or time deposits are fully insured by the Federal Deposit Insurance Corporation.

(iii) The certificates of deposit or time deposits are secured at all times, in the manner and to the extent provided by law, by collateral security described in subparagraph (A) or (B) with a market value, valued at least quarterly, of no less than the original amount of moneys so invested.

(H) Taxable money market government portfolios restricted to obligations issued or guaranteed as to payment of principal and interest by the full faith and credit of the United States.

(I) Obligations the interest on which is excluded from gross income for federal income tax purposes and money market mutual funds whose portfolios are restricted to these obligations, if the obligations or mutual funds are rated in one of the two highest rating categories by each rating agency rating those obligations.

(J) Bonds that are not issued by the United States or any federal agency, but that are listed on a national exchange and that are rated at least ''A'' by Moody's Investors Service, or the equivalent rating by Standard and Poor's Corporation or Fitch Investors Service.

(K) Bonds not listed on a national exchange that are traded on an over-the-counter basis, and that are rated at least ''Aa'' by Moody's Investors Service or ''AA'' by Standard and Poor's Corporation or Fitch Investors Service.

(j) (reserved)

(k) (reserved)

(*l*) ''Life care contract'' means a continuing care contract that includes a promise, expressed or implied, by a provider to provide or pay for routine services at all levels of care, including acute care and the services of physicians and surgeons, to the extent not covered by other public or private insurance benefits, to a resident for the duration of his or her life. Care shall be provided under a life care contract in a continuing care retirement community having a comprehensive continuum of care, including a skilled nursing facility, under the ownership and supervision of the provider on or adjacent to the premises. No change may be made in the monthly fee based on level of care. A life care contract shall also include provisions to subsidize residents who become financially unable to pay their monthly care fees.

(m) (1) ‘‘Monthly care fee’’ means the fee charged to a resident in a continuing care contract on a monthly or other periodic basis for current accommodations and services including care, board, or lodging. Periodic entrance fee payments or other prepayments shall not be monthly care fees.

(2) ‘‘Monthly fee contract’’ means a continuing care contract that requires residents to pay monthly care fees.

(n) ‘‘Nonambulatory person’’ means a person who is unable to leave a building unassisted under emergency conditions in the manner described by Section 13131.

(o) (reserved)

(p) (1) ‘‘Per capita cost’’ means a continuing care retirement community’s operating expenses, excluding depreciation, divided by the average number of residents.

(2) ‘‘Periodic charges’’ means fees paid by a resident on a periodic basis.

(3) ‘‘Permit to accept deposits’’ means a written authorization by the department permitting an applicant to enter into deposit agreements regarding a single specified continuing care retirement community.

(4) ‘‘Prepaid contract’’ means a continuing care contract in which the monthly care fee, if any, may not be adjusted to cover the actual cost of care and services.

(5) ‘‘Preferred access’’ means that residents who have previously occupied a residential living unit have a right over other persons to any assisted living or skilled nursing beds that are available at the community.

(6) ‘‘Processing fee’’ means a payment to cover administrative costs of processing the application of a depositor or prospective resident.

(7) ‘‘Promise to provide one or more elements of care’’ means any expressed or implied representation that one or more elements of care will be provided or will be available, such as by preferred access.

(8) ‘‘Proposes’’ means a representation that an applicant or provider will or intends to make a future promise to provide care, including a promise that is subject to a condition, such as the construction of a continuing care retirement community or the acquisition of a certificate of authority.

(9) ‘‘Provider’’ means an entity that provides continuing care, makes a continuing care promise, or proposes to promise to provide continuing care. ‘‘Provider’’ also includes any entity that controls an entity that provides continuing care, makes a continuing care promise, or proposes to promise to provide continuing care. The department shall determine whether an entity controls another entity for purposes of this article. No homeowner’s association, cooperative, or condominium association may be a provider.

(10) ‘‘Provisional certificate of authority’’ means the certificate issued by the department, properly executed and bearing the State Seal, under Section 1786. A provisional certificate of authority shall be limited to the specific continuing care retirement community and number of units identified in the applicant’s application.

(q) (reserved)

(r) (1) ‘‘Refund reserve’’ means the reserve a provider is required to maintain, as provided in Section 1792.6.

(2) ‘‘Refundable contract’’ means a continuing care contract that includes a promise, expressed or implied, by the provider to pay an entrance fee refund or to repurchase the transferor’s unit, membership, stock, or other interest in the continuing care retirement community when the promise to refund some or all of the initial entrance fee extends beyond the resident’s sixth year of residency. Providers that enter into refundable contracts shall be subject to the refund reserve requirements of Section 1792.6. A continuing care contract that includes a promise to repay all or a portion of an entrance fee that is conditioned upon reoccupancy or resale of the unit previously occupied by the resident shall not be considered a refundable contract for purposes of the refund reserve requirements of Section 1792.6, provided that this conditional promise of repayment is not referred to by the applicant or provider as a ‘‘refund.’’

(3) ‘‘Resale fee’’ means a levy by the provider against the proceeds from the sale of a transferor’s equity interest.

(4) ‘‘Reservation fee’’ refers to consideration collected by an entity that has made a continuing care promise or is proposing to make this promise and has complied with Section 1771.4.

(5) ‘‘Resident’’ means a person who enters into a continuing care contract with a provider, or who is designated in a continuing care contract to be a person being provided or to be provided services, including care, board, or lodging.

(6) ‘‘Residential care facility for the elderly’’ means a housing arrangement as defined by Section 1569.2.

(7) ‘‘Residential living unit’’ means a living unit in a continuing care retirement community that is not used exclusively for assisted living services or nursing services.

(s) (reserved)

(t) (1) ‘‘Termination’’ means the ending of a continuing care contract as provided for in the terms of the continuing care contract.

(2) ‘‘Transfer trauma’’ means death, depression, or regressive behavior, that is caused by the abrupt and involuntary transfer of an elderly resident from one home to another and results from a loss of familiar physical environment, loss of well-known neighbors, attendants, nurses and medical personnel, the stress of an abrupt break in the small routines of daily life, or the loss of visits from friends and relatives who may be unable to reach the new facility.

(3) ‘‘Transferor’’ means a person who transfers, or promises to transfer, consideration in exchange for care and related services under a continuing care contract or proposed continuing care contract, for the benefit of another. A transferor shall have the same rights to cancel and obtain a refund as the depositor under the deposit agreement or the resident under a continuing care contract.

SEC. 3. Section 1771.2 of the Health and Safety Code is amended to read:

1771.2. (a) An entity shall apply for and hold a currently valid permit to accept deposits before it may enter into a deposit agreement or accept a deposit.

(b) A provider shall hold a currently valid provisional certificate of authority or certificate of authority before it may enter into a continuing care contract.

(c) Before a provider subcontracts or assigns to another entity the responsibility to provide continuing care, that other entity shall have a current and valid certificate of authority. A provider holding a certificate of authority may contract for the provision of a particular aspect of continuing care, such as medical care, with another entity that does not possess a certificate of authority, if that other entity is appropriately licensed under laws of this state to provide that care, and the provider has not paid in advance for more than one year for that care.

(d) If an entity enters into an agreement to provide care for life or for more than one year to a person under 60 years of age in return for consideration, and the agreement includes the provision of services to that person after age 60, when the person turns 60 years of age, the promising entity shall comply with all the requirements imposed by this chapter.

SEC. 4. Section 1771.3 is added to the Health and Safety Code, to read:

1771.3. (a) This chapter shall not apply to either of the following:

(1) An arrangement for the care of a person by a relative.

(2) An arrangement for the care of a person or persons from only one family by a friend.

(b) This chapter shall not apply to any admission or residence agreements offered by residential communities for the elderly or residential care facilities for the elderly that promise residents preferred access to assisted living services or nursing care, when each of the following conditions is satisfied:

(1) Residents pay on a fee-for-service basis for available assisted living services and nursing care.

(2) The fees paid for available assisted living services and nursing care are the same for residents who have previously occupied a residential living unit as for residents who have not previously occupied a residential living unit.

(3) No entrance fee or prepayment for future care or access, other than monthly care fees, is paid by, or charged to, any resident at the community or facility. For purposes of this paragraph, the term entrance fee shall not include initial, deferred, or amortized payments that cumulatively do not exceed seven thousand five hundred dollars ($7,500).

(4) The provider has not made a continuing care promise of preferred access, other than a promise as described in paragraph (5).

(5) The admission or residence agreement states:

(A) ''This agreement does not guarantee that an assisted living or nursing bed will be available for residents, but, instead, promises preferred access to any assisted living or nursing beds that are available at the community or facility. The promise of preferred access gives residents who have previously occupied a residential living unit a right over other persons to such beds.''

(B) ''A continuing care contract promises that care will be provided to residents for life or for a term in excess of a year. (Name of community or facility) is not a continuing care retirement community and (name of provider) does not hold a certificate of authority to enter into continuing care contracts and is not required to have the same fiscal reserves as a continuing care provider. This agreement is not a continuing care contract and is exempted from the continuing care statutes under subdivision (b) of Section 1771.3 of the Health and Safety Code so long as the conditions set forth in that section are met.''

(6) The admission or residence agreement also states the policies and procedures regarding transfers to higher levels of care within the community or facility.

(c) Any entity may apply to the department for a Letter of Exemption stating that the requesting entity satisfies the requirements for an exemption under this section.

(d) The department shall issue a Letter of Exemption to a requesting entity if the department determines either of the following:

(1) The requesting entity satisfies each of the requirements for an exemption under subdivision (b).

(2) The requesting entity satisfies each of the requirements for an exemption under subdivision (b) other than the requirements of paragraph (2) of subdivision (b), and there is no substantial difference between the following:

(A) The fees for available assisted living services and skilled nursing care paid by residents who have previously occupied a residential living unit.

(B) The fees for available assisted living services and skilled nursing care paid by residents who have not previously occupied a residential living unit.

(e) An application to the department for a Letter of Exemption shall include all of the following:

(1) A nonrefundable one thousand dollar ($1,000) application fee.

(2) The name and business address of the applicant.

(3) A description of the services and care available or provided to residents of the community or facility.

(4) Documentation establishing that the requesting entity satisfies the requirements for an exemption under this section, including all of the following:

(A) A schedule showing all fees for assisted living services and skilled nursing care charged to residents at the facility or community who have previously occupied a residential living unit.

(B) A schedule showing all fees for assisted living services and skilled nursing care charged to residents at the facility or community who have not previously occupied a residential living unit.

(C) A description of the differences between the fees for assisted living services and skilled nursing care charged to residents who have not previously occupied a residential unit and the fees for assisted living services and skilled nursing care charged to residents who have previously occupied a residential unit.

(D) A schedule showing any other fees charged to residents of the community or facility.

(E) Copies of all admission and residence agreement forms that have been entered into, or will be entered into, with residents at the community or facility.

(5) Any other information reasonably requested by the department.

(f) If at any time any of the conditions stated in this section are not satisfied, then the requirements of this chapter apply, and the department may impose appropriate remedies and penalties set forth in Article 7 (commencing with Section 1793.5).

SEC. 5. Section 1771.4 of the Health and Safety Code is repealed.

SEC. 6. Section 1771.4 is added to the Health and Safety Code, to read:

1771.4. An entity may conduct a market test for a proposed continuing care retirement community and collect reservation fees from persons interested in residing at the proposed continuing care retirement community without violating this chapter if all of the following conditions are met:

(a) The entity has filed with the department an application for a permit to accept deposits and a certificate of authority for the project.

(b) The entity’s application includes the proposed reservation agreement form and a proposed escrow agreement that provide all of the following:

(1) All fees shall be deposited in escrow.

(2) Refunds shall be made within 10 calendar days after the payer's or proposed resident's request or 10 days after denial of the application for a permit to accept deposits.

(3) All reservation fees shall be converted to deposits within 15 days after a permit to accept deposits is issued.

(c) The department has acknowledged in writing its receipt of the entity's application and its approval of the entity's proposed reservation agreement between the payer and the entity and the escrow agreement between the escrow holder and the entity.

(d) The amount of any reservation fee collected by the entity does not exceed one thousand dollars ($1,000) or 1 percent of the average entrance fee amount as determined from the entity's application, whichever is greater.

(e) The entity places all reservation fees collected by the entity into an escrow under the terms of the approved reservation agreement and escrow agreement.

SEC. 7. Section 1771.5 of the Health and Safety Code is repealed.

SEC. 8. Section 1771.5 is added to the Health and Safety Code, to read:

1771.5. The department shall not issue a provisional certificate of authority or a certificate of authority to an applicant until the applicant has obtained licenses for the entire continuing care retirement community, including a license to operate the residential living and assisted living units, pursuant to Chapter 3.2 (commencing with Section 1569) and if a skilled nursing facility is on the premises, a license for the facility pursuant to Chapter 2 (commencing with Section 1250).

SEC. 9. Section 1771.6 of the Health and Safety Code is repealed.

SEC. 10. Section 1771.6 is added to the Health and Safety Code, to read:

1771.6. (a) Any entity may apply to the department for a Letter of Nonapplicability for reasons other than those specified in Section 1771.3, which states that the provisions of this chapter do not apply to its community, project, or proposed project.

(b) Applications for Letters of Nonapplicability shall be made to the department in writing and include the following:

(1) A nonrefundable one thousand dollar ($1,000) application fee.

(2) A list of the reasons why the existing or proposed project may not be subject to this chapter.

(3) A copy of the existing or proposed contract between the entity and residents.

(4) Copies of all advertising material.

(5) Any other information reasonably requested by the department.

(c) The department shall do both of the following:

(1) Within seven calendar days, acknowledge receipt of the request for a Letter of Nonapplicability.

(2) Within 30 calendar days after all materials are received, either issue the Letter of Nonapplicability or notify the entity of the department's reasons for denial of the request.

(d) (1) If the department determines that the entity does not qualify for a Letter of Nonapplicability, the entity shall refrain from, or immediately cease, entering into continuing care contracts.

(2) If an entity to which this subdivision applies intends to provide continuing care, an application for a certificate of authority shall be required to be filed with the department pursuant to this chapter.

(3) If an entity to which this subdivision applies does not intend to provide continuing care, it shall alter its plan of operation so that the project is not subject to this chapter. To obtain a Letter of Nonapplicability for the revised project, the entity shall submit a new application and fee.

SEC. 11. Section 1771.7 of the Health and Safety Code is repealed.

SEC. 12. Section 1771.7 is added to the Health and Safety Code, to read:

1771.7. (a) No resident of any continuing care retirement community shall be deprived of any civil or legal right, benefit, or privilege guaranteed by law, by the California Constitution, or by the United States Constitution solely by reason of status as a resident of a community. In addition, because of the discretely different character of residential living unit programs that are a part of continuing care retirement communities, this section shall augment Chapter 3.9 (commencing with Section 1599), Section 73523 of Title 22 of the California Code of Regulations, and applicable federal law and regulations.

(b) All residents in residential living units shall have all of the following rights:

(1) To live in an attractive, safe, and well maintained physical environment.

(2) To live in an environment that enhances personal dignity, maintains independence, and encourages self-determination.

(3) To participate in activities that meet individual physical, intellectual, social, and spiritual needs.

(4) To expect effective channels of communication between residents and staff, and between residents and the administration or provider's governing body.

(5) To receive a clear and complete written contract that establishes the mutual rights and obligations of the resident and the continuing care retirement community.

(6) To maintain and establish ties to the local community.

(c) A continuing care retirement community shall maintain an environment that enhances the residents' self-determination and independence. The provider shall do both of the following:

(1) Permit the formation of a resident association by interested residents who may elect a governing body. The provider shall

provide space and post notices for meetings, and provide assistance in attending meetings for those residents who request it. In order to permit a free exchange of ideas, at least part of each meeting shall be conducted without the presence of any continuing care retirement community personnel. The association may, among other things, make recommendations to management regarding resident issues that impact the residents' quality of life. Meetings shall be open to all residents to attend as well as to present issues. Executive sessions of the governing body shall be attended only by the governing body.

(2) Establish policies and procedures that promote the sharing of information, dialogue between residents and management, and access to the provider's governing body. The policies and procedures shall be evaluated at a minimum of every two years by the continuing care retirement community administration to determine their effectiveness in maintaining meaningful resident-management relations.

(d) In addition to any statutory or regulatory bill of rights required to be provided to residents of residential care facilities for the elderly or skilled nursing facilities, the provider shall provide a copy of the bill of rights prescribed by this section to each resident at or before the resident's admission to the community.

(e) The department may, upon receiving a complaint of a violation of this section, request a copy of the policies and procedures along with documentation on the conduct and findings of any self-evaluations and consult with the Continuing Care Advisory Committee for determination of compliance.

(f) Failure to comply with this section shall be grounds for suspension, condition, or revocation of the provisional certificate of authority or certificate of authority pursuant to Section 1793.21.

SEC. 13. Section 1771.8 of the Health and Safety Code is repealed.

SEC. 14. Section 1771.9 of the Health and Safety Code is amended and renumbered to read:

1771.8. (a) The Legislature finds and declares all of the following:

(1) The residents of continuing care retirement communities have a unique and valuable perspective on the operations of and services provided in the community in which they live.

(2) Resident input into decisions made by the provider is an important factor in creating an environment of cooperation, reducing conflict, and ensuring timely response and resolution to issues that may arise.

(3) Continuing care retirement communities are strengthened when residents know that their views are heard and respected.

(b) The Legislature encourages continuing care retirement communities to exceed the minimum resident participation requirements established by this section by, among other things, the following:

(1) Encouraging residents to form a resident association, and assisting the residents, the resident association, and its governing body to keep informed about the operation of the continuing care retirement community.

(2) Encouraging residents of a continuing care retirement community or their elected representatives to select residents to participate as board members of the governing body of the provider.

(3) Quickly and fairly resolving any dispute, claim, or grievance arising between a resident and the continuing care retirement community.

(c) The governing body of a provider, or the designated representative of the provider, shall hold, at a minimum, semiannual meetings with the residents of the continuing care retirement community, or the resident association or its governing body, for the purpose of the free discussion of subjects including, but not limited to, income, expenditures, and financial trends and issues as they apply to the continuing care retirement community and proposed changes in policies, programs, and services. Nothing in this section precludes a provider from taking action or making a decision at any time, without regard to the meetings required under this subdivision.

(d) At least 30 days prior to the implementation of any increase in the monthly care fee, the designated representative of the provider shall convene a meeting, to which all residents shall be invited, for the purpose of discussing the reasons for the increase, the basis for determining the amount of the increase, and the data used for calculating the increase. This meeting may coincide with the semiannual meetings provided for in subdivision (c).

(e) The governing body of a provider, or the designated representative of the provider shall provide residents with at least 14 days' advance notice of each meeting provided for in subdivisions (c) and (d). The governing body of a provider, or the designated representative of the provider shall post the notice of, and the agenda for, the meeting in a conspicuous place in the continuing care retirement community at least 14 days prior to the meeting. The governing body of a provider, or the designated representative of the provider shall make available to residents of the continuing care retirement community upon request the agenda and accompanying materials at least seven days prior to the meeting.

(f) Each provider shall make available to the resident association or its governing body, or if neither exists, to a committee of residents, a financial statement of activities comparing actual costs to budgeted costs broken down by expense category, not less than semiannually, and shall consult with the resident association or its governing body, or if neither exists to a committee of residents, during the annual budget planning process.

(g) Each provider shall, within 10 days after the annual report required pursuant to Section 1790 is submitted to the department,

provide, at a central and conspicuous location in the community, a copy of the annual report, including a copy of the annual audited financial statement, but excluding personal confidential information.

(h) Each provider shall maintain, as public information, available upon request to residents, prospective residents, and the public, minutes of the board of director's meetings and shall retain these records for at least three years from the date the records were filed or issued.

(i) The governing body of a provider that is not part of a multifacility organization with more than one continuing care retirement community in the state shall accept at least one resident of the continuing care retirement community it operates to participate as a nonvoting resident representative to the provider's governing body.

(j) In a multifacility organization having more than one continuing care retirement community in the state, the governing body of the multifacility organization shall elect either to have at least one nonvoting resident representative to the provider's governing body for each California-based continuing care retirement community the provider operates or to have a resident-elected committee composed of representatives of the residents of each California-based continuing care retirement community that the provider operates select or nominate at least one nonvoting resident representative to the provider's governing body for every three California-based continuing care retirement communities or fraction thereof that the provider operates.

(k) In order to encourage innovative and alternative models of resident involvement, a resident selected pursuant to subdivision (i) to participate as a resident representative to the provider's governing body may, at the option of the resident association, be selected in any one of the following ways:

(1) By a majority vote of the resident association of a provider or by a majority vote of a resident-elected committee of residents of a multifacility organization.

(2) If no resident association exists, any resident may organize a meeting of the majority of the residents of the continuing care retirement community to select or nominate residents to represent them before the governing body.

(3) Any other method designated by the resident association.

(*l*) The resident association, or organizing resident, or in the case of a multifacility organization, the resident-elected committee of residents, shall give residents of the continuing care retirement community at least 30 days' advance notice of the meeting to select a resident representative and shall post the notice in a conspicuous place at the continuing care retirement community.

(m) Except as provided in subdivision (n), the resident representative shall receive the same notice of board meetings,

board packets, minutes, and other materials as members and shall be permitted to attend, speak, and participate in all meetings of the board.

(n) Notwithstanding subdivision (m), the governing body may exclude resident representatives from its executive sessions and from receiving board materials to be discussed during executive session. However, resident representatives shall be included in executive sessions and shall receive all board materials to be discussed during executive sessions related to discussions of the annual budgets, increases in monthly care fees, indebtedness, and expansion of new and existing continuing care retirement communities.

(o) The provider shall pay all reasonable travel costs for the resident representative.

(p) The provider shall disclose in writing the extent of resident involvement with the board to prospective residents.

(q) Nothing in this section prohibits a provider from exceeding the minimum resident participation requirements of this section by, for example, having more resident meetings or more resident representatives to the board than required or by having one or more residents on the provider's governing body who are selected with the active involvement of residents.

(r) On or before January 1, 2001, the Continuing Care Advisory Committee of the department established pursuant to Section 1777 shall evaluate and report to the Legislature on the implementation of this section.

SEC. 15. Section 1771.11 of the Health and Safety Code is amended and renumbered to read:

1771.10. Each provider shall adopt a comprehensive disaster preparedness plan specifying policies for evacuation, relocation, continued services, reconstruction, organizational structure, insurance coverage, resident education, and plant replacement.

SEC. 16. Section 1772 of the Health and Safety Code is amended to read:

1772. (a) No report, circular, public announcement, certificate, financial statement, or any other printed matter or advertising material, or oral representation, that states or implies that an entity sponsors, guarantees, or assures the performance of any continuing care contract, shall be published or presented to any prospective resident unless both of the following have been met:

(1) Paragraph (5) of subdivision (a) of Section 1788 applies and the requirements of that paragraph have been satisfied.

(2) The entity files with the department a duly authorized and executed written declaration that it accepts full financial responsibility for each continuing care contract. The filing entity shall be subject to the application requirements set forth in Article 2 (commencing with Section 1779), shall be a coobligor for the

subject contracts, and shall be a coprovider on the applicable provisional certificate of authority and certificate of authority.

(b) Implied sponsorship includes the use of the entity's name for the purpose of implying that the entity's reputation may be relied upon to ensure the performance of the continuing care contract.

(c) Any implication that the entity may be financially responsible for these contracts may be rebutted by a conspicuous statement, in all continuing care contracts and marketing materials, that clearly discloses to prospective residents and all transferors that the entity is not financially responsible.

(d) On written appeal to the department, and for good cause shown, the department may, in its discretion, allow an affinity group exemption from this section. If an exemption is granted, every continuing care contract shall include a conspicuous statement which clearly discloses to prospective residents and all transferors that the affinity group entity is not financially responsible.

(e) If the name of an entity, including, but not limited to, a religion, is used in connection with the development, marketing, or continued operation of a continuing care retirement community, but that entity does not actually own, control, manage, or otherwise operate the continuing care retirement community, the provider shall clearly disclose the absence of that affiliation, involvement, or association with the continuing care retirement community in the continuing care contract.

SEC. 17. Section 1772.2 is added to the Health and Safety Code, to read:

1772.2. (a) All printed advertising materials, including brochures, circulars, public announcements, and similar publications pertaining to continuing care or a continuing care retirement community shall specify the number on the provider's provisional certificate of authority or certificate of authority.

(b) If the provider has not been issued a certificate of authority, all advertising materials shall specify both of the following:

(1) Whether an application has been filed.

(2) If applicable, that a permit to accept deposits or a provisional certificate of authority has been issued.

SEC. 18. Section 1773 of the Health and Safety Code is amended to read:

1773. (a) A provisional certificate of authority or certificate of authority may not be sold, transferred, or exchanged in any manner. A provider may not sell or transfer ownership of the continuing care retirement community without the approval of the department. Any violation of this section shall cause the applicable provisional certificate of authority or certificate of authority to be forfeited by operation of law pursuant to subdivision (c) of Section 1793.7.

(b) A provider may not enter into a contract with a third party for overall management of the continuing care retirement community

without the approval of the department. The department shall review the transaction for consistency with this chapter.

(c) Any violation of this section shall be grounds for revocation for the provider's provisional certificate of authority or certificate of authority under Section 1793.21.

SEC. 19. Section 1774 of the Health and Safety Code is amended to read:

1774. No arrangement allowed by a permit to accept deposits, a provisional certificate or authority, or a certificate of authority issued by the department under this chapter may be deemed a security for any purpose.

SEC. 20. Section 1775 of the Health and Safety Code is amended to read:

1775. (a) To the extent that this chapter, as interpreted by the department, conflicts with the statutes, regulations, or interpretations governing the sale or hire of real property, this chapter shall prevail.

(b) Notwithstanding any law or regulation to the contrary, a provider for a continuing care retirement community may restrict or abridge the right of any resident, whether or not the resident owns an equity interest, to sell, lease, encumber, or otherwise convey any interest in the resident's unit, and may require that the resident only sell, lease, or otherwise convey the interest to persons approved by the provider. Provider approval may be based on factors which include, but are not limited to, age, health status, insurance risk, financial status, or burden on the provider's personnel, resources, or physical facility. The provider shall record any restrictions on a real property interest.

(c) To the extent that this chapter conflicts with Sections 51.2 and 51.3 of the Civil Code, this chapter shall have precedence. A continuing care provider, at its discretion, may limit entrance based on age.

(d) This chapter imposes minimum requirements upon any entity promising to provide, proposing to promise to provide, or providing continuing care.

(e) This chapter shall be liberally construed for the protection of persons attempting to obtain or receiving continuing care.

(f) A resident's entry into a continuing care contract described in this chapter shall be presumptive evidence of the resident's intent not to return to his or her prior residence to live for purposes of qualifying for Medi-Cal coverage under Sections 14000 et seq. of the Welfare and Institutions Code and Section 50425 of Title 22 of the California Code of Regulations.

SEC. 21. Section 1776.6 of the Health and Safety Code is amended to read:

1776.6. (a) Pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title

1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code), the following documents are public information and shall be provided by the department upon request: audited financial statements, annual reports and accompanying documents, compliance or noncompliance with reserve requirements, whether an application for a permit to accept deposits and certificate of authority has been filed, whether a permit or certificate has been granted or denied, and the type of care offered by the provider.

(b) The department shall regard resident data used in the calculation of reserves as confidential.

SEC. 22. Section 1777 of the Health and Safety Code is amended to read:

1777. (a) The Continuing Care Advisory Committee of the department shall act in an advisory capacity to the department on matters relating to continuing care contracts.

(b) The members of the committee shall include:

(1) Three representatives of nonprofit continuing care providers pursuant to this chapter, each of whom shall have offered continuing care services for at least five years prior to appointment. One member shall represent a multifacility provider and shall be appointed by the Governor in even years. One member shall be appointed by the Senate Committee on Rules in odd years. One member shall be appointed by the Speaker of the Assembly in odd years.

(2) Three senior citizens who are not eligible for appointment pursuant to paragraphs (1) and (4) who shall represent consumers of continuing care services, at least two of whom shall be residents of continuing care retirement communities but not residents of the same provider. One senior citizen member shall be appointed by the Governor in even years. One senior citizen member shall be appointed by the Senate Committee on Rules in odd years. One senior citizen member shall be appointed by the Speaker of the Assembly in odd years.

(3) A certified public accountant with experience in the continuing care industry, who is not a provider of continuing care services. This member shall be appointed by the Governor in even years.

(4) A representative of a for-profit provider of continuing care contracts pursuant to this chapter. This member shall be appointed by the Governor in even years.

(5) An actuary. This member shall be appointed by the Governor in even years.

(c) Commencing January 1, 1997, all members shall serve two-year terms and be appointed based on their interest and expertise in the subject area. The Governor shall designate the

chairperson for the committee with the advice and consent of the Senate. A member may be reappointed at the pleasure of the appointing power. The appointing power shall fill all vacancies on the committee within 60 days. All members shall continue to serve until their successors are appointed and qualified.

(d) The members of the committee shall serve without compensation, except that each member shall be paid from the Continuing Care Provider Fee Fund a per diem of twenty-five dollars ($25) for each day's attendance at a meeting of the committee not to exceed six days in any month. The members of the committee shall also receive their actual and necessary travel expenses incurred in the course of their duties. Reimbursement of travel expenses shall be at rates not to exceed those applicable to comparable state employees under Department of Personnel Administration regulations.

(e) Prior to commencement of service, each member shall file with the department a statement of economic interest and a statement of conflict of interest pursuant to Article 3 (commencing with Section 87300) of the Government Code.

(f) If, during the period of appointment, any member no longer meets the qualifications of subdivision (b), that member shall submit his or her resignation to their appointing power and a qualified new member shall be appointed by the same power to fulfill the remainder of the term.

SEC. 23. Section 1777.2 of the Health and Safety Code is amended to read:

1777.2. (a) The Continuing Care Advisory Committee shall:

(1) Review the financial and managerial condition of continuing care retirement communities operating under a certificate of authority.

(2) Review the financial condition of any continuing care retirement community that the committee determines is indicating signs of financial difficulty and may be in need of close supervision.

(3) Monitor the condition of those continuing care retirement communities that the department or the chair of the committee may request.

(4) Make available consumer information on the selection of continuing care contracts and necessary contract protections in the purchase of continuing care contracts.

(5) Review new applications regarding financial, actuarial, and marketing feasibility as requested by the department.

(b) The committee shall make recommendations to the department regarding needed changes in its rules and regulations and upon request provide advice regarding the feasibility of new continuing care retirement communities and the correction of problems relating to the management or operation of any continuing care retirement community. The committee shall also perform any

other advisory functions necessary to improve the management and operation of continuing care retirement communities.

(c) The committee may report on its recommendations directly to the director of the department.

(d) The committee may hold meetings, as deemed necessary to the performance of its duties.

SEC. 24. Section 1777.4 of the Health and Safety Code is amended to read:

1777.4. Any member of the Continuing Care Advisory Committee is immune from civil liability based on acts performed in his or her official capacity. Costs of defending civil actions brought against a member for acts performed in his or her official capacity shall be borne by the complainant. However, nothing in this section immunizes any member for acts or omissions performed with malice or in bad faith.

SEC. 25. Section 1779 of the Health and Safety Code is amended to read:

1779. (a) An entity shall file an application for a permit to accept deposits and for a certificate of authority with the department, as set forth in this chapter, before doing any of the following:

(1) Accepting any deposit, reservation fee, or any other payment that is related to a promise or proposal to promise to provide continuing care.

(2) Entering into any reservation agreement, deposit agreement, or continuing care contract.

(3) Commencing construction of a prospective continuing care retirement community. If the project is to be constructed in phases, the application shall include all planned phases.

(4) Expanding an existing continuing care retirement community whether by converting existing buildings or by new construction.

(5) Converting an existing structure to a continuing care retirement community.

(6) Recommencing marketing on a planned continuing care retirement community when the applicant has previously forfeited a permit to accept deposits pursuant to Section 1703.7.

(7) Executing new continuing care contracts after a provisional certificate of authority or certificate of authority has been inactivated, revoked, surrendered, or forfeited.

(8) Closing the sale or transfer of a continuing care retirement community or assuming responsibility for continuing care contracts.

(b) For purposes of paragraph (4) of subdivision (a), an expansion of a continuing care retirement community shall be deemed to occur when there is an increase in the capacity stated on the residential care facility for the elderly license issued to the continuing care retirement community, an increase in the number of units at the continuing care retirement community, an increase in the number of skilled nursing beds, or additions to or replacement of existing

continuing care retirement community structures that may affect obligations to current residents.

(c) Any provider that alters, or proposes to alter, its organization, including by means of a change in the type of entity it is, separation from another entity, merger, affiliation, spinoff, or sale, shall file a new application and obtain a new certificate of authority before the new entity may enter into any new continuing care contracts.

(d) A new application shall not be required for an entity name change if there is no change in the entity structure or management. If the provider undergoes a name change, the provider shall notify the department in writing of the name change and shall return the previously issued certificate of authority for reissuance under the new name.

(e) Within 10 days of submitting an application for a certificate of authority pursuant to paragraph (3), (4), (7), or (8) of subdivision (a), the provider shall notify residents of the provider's existing community or communities of its application. The provider shall notify its resident associations of any filing with the department to obtain new financing, additional financing for a continuing care retirement community, the sale or transfer of a continuing care retirement community, any change in structure, and of any applications to the department for any expansion of a continuing care retirement community. A summary of the plans and application shall be posted in a prominent location in the continuing care retirement community so as to be accessible to all residents and the general public, indicating in the summary where the full plans and application may be inspected in the continuing care retirement community.

(f) When the department determines that it has sufficient information on the provider or determines that the provisions do not apply and the protections provided by this article are not compromised, the department may eliminate all or portions of the application contents required under Section 1779.4 for applications filed pursuant to paragraphs (4), (5), (6), (7), and (8) of subdivision (a) or pursuant to subdivision (c).

SEC. 26. Section 1779.2 of the Health and Safety Code is amended to read:

1779.2. (a) Any entity filing an application for a permit to accept deposits and a certificate of authority shall pay an application fee.

(b) The applicant shall pay 80 percent of the application fee for all planned phases at the time the applicant submits its application. The 80 percent payment shall be made by check payable to the Continuing Care Provider Fee Fund. The department shall not process the application until it has received this fee.

(c) For new continuing care retirement communities or for the sale or transfer of existing continuing care retirement communities, the application fee shall be calculated as one-tenth of 1 percent of the

purchase price of the continuing care retirement community, or the estimated construction cost, including the purchase price of the land or the present value of any long-term lease and all items listed in subparagraph (D) of paragraph (2) of subdivision (y) of Section 1779.4.

(d) For existing continuing care retirement communities that are proposing new phases, remodeling or an expansion, the application fee shall be calculated as one-tenth of 1 percent of the cost of the addition, annexation, or renovation, including the value of the land and improvements and all items listed in subparagraph (D) of paragraph (2) of subdivision (y) of Section 1779.4.

(e) For existing facilities converting to continuing care retirement communities, the application fee shall be calculated as one-tenth of 1 percent of the current appraised value of the facility, including the land, or present value of any long-term lease.

(f) For organizational changes, the application fee shall be determined by the department based on the time and resources it considers reasonably necessary to process the application, including any consultant fees. The minimum application fee for those applications shall be two thousand dollars ($2,000).

(g) The applicant shall pay the remainder of the application fee before the provisional certificate of authority is issued, or in the case of expansions or remodeling, before final approval of the project is granted. The applicant shall make this payment by check payable to the Continuing Care Provider Fee Fund.

SEC. 27. Section 1779.4 of the Health and Safety Code is amended to read:

1779.4. An application shall contain all of the following:

(a) A statement signed by the applicant under penalty of perjury certifying that to the best of the applicant’s knowledge and belief, the items submitted in the application are correct. If the applicant is a corporation, the chief executive officer shall sign the statement. If there are multiple applicants, these requirements shall apply to each applicant.

(b) The name and business address of the applicant.

(c) An itemization of the total fee calculation, including sources of figures used, and a check in the amount of 80 percent of the total application fee.

(d) The name, address, and a description of the real property of the continuing care retirement community.

(e) An estimate of the number of continuing care residents at the continuing care retirement community.

(f) A description of the proposed continuing care retirement community, including the services and care to be provided to residents or available for residents.

(g) A statement indicating whether the application is for a certificate of authority to enter into continuing care or life care contracts.

(h) A license to operate the proposed continuing care retirement community as a residential care facility for the elderly or documentation establishing that the applicant has received a preliminary approval for licensure from the department's Community Care Licensing Division.

(i) A license to operate the proposed skilled nursing facility or evidence that an application has been filed with the Licensing and Certification Division of the State Department of Health Services, if applicable.

(j) A statement disclosing any revocation or other disciplinary action taken, or in the process of being taken, against a license, permit, or certificate held or previously held by the applicant.

(k) A description of any matter in which any interested party involved with the proposed continuing care retirement community has been convicted of a felony or pleaded nolo contendere to a felony charge, or been held liable or enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or the misappropriation of property. For the purpose of this subdivision, ''interested party'' includes any representative of the developer of the proposed continuing care retirement community or the applicant, including all general partners, executive officers, or chief operating officers and board members of corporations; and managing members and managers of limited liability companies for each entity; who has significant decisionmaking authority with respect to the proposed continuing care retirement community.

(*l*) If the applicant is an entity other than an individual, the following information shall also be submitted:

(1) A statement identifying the type of legal entity and listing the interest and extent of the interest of each principal in the legal entity. For the purposes of this paragraph, ''principal'' means any person or entity having a financial interest in the legal entity of 10 percent or more. When the application is submitted in the name of a corporation, the parent, sole corporate shareholder, or sole corporate member who controls the operation of the continuing care retirement community shall be listed as an applicant. When multiple corporate applicants exist, they shall be listed jointly by corporate name on the application, and the certificate of authority shall be issued in the joint names of the corporations. When the application is submitted by a partnership, all general partners shall be named as coapplicants and the department shall name them as coproviders on any certificate of authority it issues.

(2) The names of the members of the provider's governing body.

(3) A statement indicating whether the applicant was or is affiliated with a religious, charitable, nonprofit or for-profit organization, and the extent of any affiliation. The statement shall also include the extent, if any, to which the affiliate organization will be responsible for the financial and contract obligations of the applicant and shall be signed by a responsible officer of the affiliate organization.

(4) A statement identifying any parent entity or other affiliate entity, the primary activities of each entity identified, the relationship of each entity to the applicant, and the interest in the applicant held by each entity.

(5) Copies of all contracts, management agreements, or other documents setting forth the relationships with each of the other entities.

(6) A statement indicating whether the applicant, a principal, a parent entity, affiliate entity, subsidiary entity, any responsible employee, manager, or board member, or anyone who profits from the continuing care retirement community has had applied against it any injunctive or restrictive order of a court of record, or any suspension or revocation of any state or federal license, permit, or certificate, arising out of or relating to business activity of health or nonmedical care, including, but not limited to, actions affecting a license to operate a health care institution, nursing home, intermediate care facility, hospital, home health agency, residential care facility for the elderly, community care facility, or child day care facility.

(m) A description of the business experience of the applicants in the operation or management of similar facilities.

(n) A copy of any advertising material regarding the proposed continuing care retirement community prepared for distribution or publication.

(o) Evidence of the bonds required by Section 1789.8.

(p) A copy of any proposed reservation agreement.

(q) A copy of the proposed deposit agreements.

(r) The name of the proposed escrow agent and depository.

(s) Any copies of reservation and deposit escrow account agreements.

(t) A copy of any proposed continuing care contracts.

(u) A statement of any monthly care fees to be paid by residents, the components and services considered in determining the fees, and the manner by which the provider may adjust these fees in the future. If the continuing care retirement community is already in operation, or if the provider operates one or more similar continuing care retirement communities within this state, the statement shall include tables showing the frequency and each percentage increase in monthly care rates at each continuing care retirement community for the previous five years, or any shorter period for which each

continuing care retirement community may have been operated by the provider or his or her predecessor in interest.

(v) A statement of the actions that have been, or will be, taken by the applicant to fund reserves as required by Section 1792 or 1792.6 and to otherwise ensure that the applicant will have adequate finances to fully perform continuing care contract obligations. The statement shall describe actions such as establishing restricted accounts, sinking funds, trust accounts, or additional reserves. If the applicant is purchasing an existing continuing care retirement community from a selling provider, the applicant shall provide an actuarial report to determine the liabilities of existing continuing care contracts and demonstrate the applicant's ability to fund those obligations.

(w) A copy of audited financial statements for the three most recent fiscal years of the applicant or any shorter period of time the applicant has been in existence, prepared in accordance with generally accepted accounting principles and accompanied by an independent auditor's report from a reputable firm of certified public accountants. The audited financial statements shall be accompanied by a statement signed and dated by both the chief financial officer and chief executive officer for the applicant or, if applicable, by each general partner, or each managing member and manager, stating that the financial statements are complete, true, and correct in all material matters to the best of their knowledge.

(x) Unaudited interim financial statements shall be included if the applicant's fiscal year ended more than 90 days prior to the date of filing. The statements shall be either quarterly or monthly, and prepared on the same basis as the annual audited financial statements or any other basis acceptable to the department.

(y) A financial study and a marketing study that reasonably project the feasibility of the proposed continuing care retirement community and are prepared by a firm or firms acceptable to the department. These studies shall address and evaluate, at a minimum, all of the following items:

(1) The applicant and its prior experience, qualifications, and management, including a detailed description of the applicant's proposed continuing care retirement community, its service package, fee structure, and anticipated opening date.

(2) The construction plans, construction financing, and permanent financing for the proposed continuing care retirement community, including a description of the anticipated source, cost, terms, and use of all funds to be used in the land acquisition, construction, and operation of the continuing care retirement community. This proposal shall include, at a minimum, all of the following:

(A) A description of all debt to be incurred by the applicant for the continuing care retirement community, including the anticipated

terms and costs of the financing. The applicant's outstanding indebtedness related to the continuing care retirement community may not, at any time, exceed the appraised value of the continuing care retirement community.

(B) A description of the source and amount of the equity to be contributed by the applicant.

(C) A description of the source and amount of all other funds, including entrance fees, that will be necessary to complete and operate the continuing care retirement community.

(D) A statement itemizing all estimated project costs, including the real property costs and the cost of acquiring or designing and constructing the continuing care retirement community, and all other similar costs that the provider expects to incur prior to the commencement of operation. This itemization shall identify all costs related to the continuing care retirement community or project, including financing expenses, legal expenses, occupancy development costs, marketing costs, and furniture and equipment.

(E) A description of the interest expense, insurance premiums, and property taxes that will be incurred prior to opening.

(F) An estimate of any proposed continuing care retirement community reserves required for items such as debt service, insurance premiums, and operations.

(G) An estimate of the amount of funds, if any, that will be necessary to fund startup losses, fund statutory and refundable contract reserves, and to otherwise provide additional financial resources in an amount sufficient to ensure full performance by the provider of its continuing care contract obligations.

(3) An analysis of the potential market for the applicant's continuing care retirement community, addressing such items as:

(A) A description of the service area, including its demographic, economic, and growth characteristics.

(B) A forecast of the market penetration the continuing care retirement community will achieve based on the proposed fee structure.

(C) Existing and planned competition in and about the primary service area.

(4) A detailed description of the sales and marketing plan, including all of the following:

(A) Marketing projections, anticipated sales, and cancellation rates.

(B) Month-by-month forecast of unit sales through sellout.

(C) A description of the marketing methods, staffing, and advertising media to be used by the applicant.

(D) An estimate of the total entrance fees to be received from residents prior to opening the continuing care retirement community.

(5) Projected move-in rates, deposit collections, and resident profiles, including couple mix by unit type, age distribution, care and nursing unit utilization, and unit turnover or resale rates.

(6) A description or analysis of development-period costs and revenues throughout the development of the proposed continuing care retirement community.

(z) Projected annual financial statements for the period commencing on the first day of the applicant's current fiscal year through at least the fifth year of operation.

(1) Projected annual financial statements shall be prepared on an accrual basis using the same accounting principles and procedures as the audited financial statements furnished pursuant to subdivision (x).

(2) Separate projected annual cash-flow statements shall be provided. These statements shall show projected annual cash-flows for the duration of any debt associated with the continuing care retirement community. If the continuing care retirement community property is leased, the cash-flow statement shall demonstrate the feasibility of closing the continuing care retirement community at the end of the lease period.

(A) The projected annual cash-flow statements shall be submitted using prevailing rates of interest, and assume no increase of revenues and expenses due to inflation.

(B) The projected annual cash-flow statements shall include all of the following:

(i) A detailed description and a full explanation of all assumptions used in preparing the projections, accompanied by supporting supplementary schedules and calculations, all to be consistent with the financial study and marketing study furnished pursuant to subdivision (y). The department may require such other supplementary schedules, calculations, or projections as it determines necessary for an adequate application.

(ii) Cash-flow from monthly operations showing projected revenues for monthly fees received from continuing care contracts, medical unit fees if applicable, other periodic fees, gifts and bequests used in operations, and any other projected source of revenue from operations less operating expenses.

(iii) Contractual cash-flow from activities showing projected revenues from presales, deposit receipts, entrance fees, and all other projected sources of revenue from activities, less contract acquisition, marketing, and advertising expenditures.

(iv) Cash-flows from financing activities, including, but not limited to, bond or loan proceeds less bond issue or loan costs and fees, debt service including CAL Mortgage Insurance premiums, trustee fees, principal and interest payments, leases, contracts, rental agreements, or other long-term financing.

(v) Cash-flows from investment activities, including, but not limited to, construction progress payments, architect and engineering services, furnishings, and equipment not included in the construction contract, project development, inspection and testing, marketable securities, investment earnings, and interfund transfers.

(vi) The increase or decrease in cash during the projection period.

(vii) The beginning cash balance, which means cash, marketable securities, reserves, and other funds on hand, available, and committed to the proposed continuing care retirement community.

(viii) The cash balance at the end of the period.

(ix) Details of the components of the ending cash balance shall be provided for each period presented, including, but not limited to, the ending cash balances for bond reserves, other reserve funds, deposit funds, and construction funds balance.

(3) If the cash-flow statements required by paragraph (2) indicate that the provider will have cash balances exceeding two months' projected operating expenses of the continuing care retirement community, a description of the manner in which the cash balances will be invested, and the persons who will be making the investment decisions, shall accompany the application.

(4) The department may require the applicant to furnish additional data regarding its operating budgets, projections of cash required for major repairs and improvements, or any other matter related to its projections including additional information, schedules, and calculations regarding occupancy rate projections, unit types, couple mix, sex and age estimates for resident mix, turnover rates, refund obligations, and sales.

(aa) (1) A declaration by the applicant acknowledging that it is required to execute and record a Notice of Statutory Limitation on Transfer relating to continuing care retirement community property.

(2) The notice required in this subdivision shall be acknowledged and suitable for recordation, describe the property, declare the applicant's intention to use all or part of the described property for the purposes of a continuing care retirement community pursuant to this chapter, and shall be in substantially the following form:

''NOTICE OF STATUTORY LIMITATION ON TRANSFER

Notice is hereby given that the property described below is licensed, or proposed to be licensed, for use as a continuing care retirement community and accordingly, the use and transfer of the property is subject to the conditions and limitations as to use and transfer set forth in Sections 1773 and 1789.4 of the Health and Safety Code. This notice is recorded pursuant to subdivision (aa) of Section 1779.4 of the Health and Safety Code.

The real property, which is legally owned by (insert the name of the legal owner) and is the subject of the statutory limitation to which this notice refers, is more particularly described as follows: (Insert the legal description and the assessor's parcel number of the real property to which this notice applies.)''

(3) The Notice of Statutory Limitation on Transfer shall remain in effect until notice of release is given by the department. The department shall execute and record a release of the notice upon proof of complete performance of all obligations to residents.

(4) Unless a Notice of Statutory Limitation on Transfer has been recorded with respect to the land on which the applicant or provider is operating, or intends to operate a continuing care retirement community, prior to the date of execution of any trust deed, mortgage, or any other lien or encumbrance securing or evidencing the payment of money and affecting land on which the applicant or provider intends to operate a continuing care retirement community, the applicant or provider shall give the department advance written notice of the proposed encumbrance. Upon the giving of notice to the department, the applicant or provider shall execute and record the Notice of Statutory Limitation on Transfer in the office of the county recorder in each county in which any portion of the continuing care retirement community is located prior to encumbering the continuing care retirement community property with the proposed encumbrance.

(5) In the event that the applicant or provider and the owner of record are not the same entity on the date on which execution and recordation of the notice is required, the leasehold or other interest in the continuing care retirement community property held by the applicant or provider shall survive in its entirety and without change, any transfer of the continuing care retirement community property by the owner. In addition, the applicant or provider shall record a memorandum of leasehold or other interest in the continuing care retirement community property that includes a provision stating that its interest in the property survives any transfer of the property by the owner. The applicant or provider shall provide a copy of the notice and the memorandum of interest to the owner of record by certified mail and to the department.

(6) The notice shall, and, if applicable, the memorandum of interest shall be indexed by the recorder in the grantor-grantee index to the name of the owner of record and the name of the applicant or provider.

(ab) A statement that the applicant will keep the department informed of any material changes to the proposed continuing care retirement community or its application.

(ac) Any other information that may be required by the department for the proper administration and enforcement of this chapter.

SEC. 28. Section 1779.6 of the Health and Safety Code is amended to read:

1779.6. (a) Within seven calendar days of receipt of an initial application for a permit to accept deposits and a certificate of authority, the department shall acknowledge receipt of the application in writing.

(b) Within 30 calendar days following its receipt of an application, the department shall determine if the application is complete and inform the applicant of its determination. If the department determines that the application is incomplete, its notice to the applicant shall identify the additional forms, documents, information, and other materials required to complete the application. The department shall allow the applicant adequate time to submit the requested information and materials. This review may not determine the adequacy of the materials included in the application.

(c) Within 120 calendar days after the department determines that an application is complete, the department shall review the application for adequacy. An application shall be adequate if it complies with all the requirements imposed by this chapter, and both the financial study and marketing study reasonably project the feasibility of the proposed continuing care retirement community, as well as demonstrate the financial soundness of the applicant. The department shall either approve the application as adequate under this chapter or notify the applicant that its application is inadequate. If the application is inadequate, the department shall identify the deficiencies in the application, provide the appropriate code references, and give the applicant an opportunity to respond.

(d) Within 60 calendar days after receiving any additional information or clarification required from the applicant, the department shall respond to the applicant's submission in writing and state whether each specific deficiency has been addressed sufficiently to make the application adequate. If the department determines that the application is adequate and in compliance with this chapter, the department shall issue the permit to accept deposits. If the department determines that the response is inadequate, it may request additional information or clarification from the applicant pursuant to subdivision (c) or deny the application pursuant to Section 1779.10.

(e) If the applicant does not provide the department with the additional information within 90 days after the department's notice described in subdivision (c), the application may be denied for being inadequate. Any new application shall require an application fee.

SEC. 28.5. Section 1779.7 is added to the Health and Safety Code, to read:

1779.7. (a) Where any portion of the consideration transferred to an applicant as a deposit or to a provider as consideration for a continuing care contract is transferred by a person other than the prospective resident or a resident, that third-party transferor shall have the same cancellation or refund rights as the prospective resident or resident for whose benefit this consideration was transferred.

(b) A transferor shall have the same rights to cancel and obtain a refund as the depositor under the deposit agreement or the resident under a continuing care contract.

SEC. 29. Section 1779.8 of the Health and Safety Code is amended to read:

1779.8. (a) The applicant shall notify the department of material changes in the application information submitted to the department, including the applicant's financial and marketing projections.

(b) An applicant shall provide to the department at least 60 days' advance written notice of any proposal to make any changes in the applicant's corporate name, structure, organization, operation, or financing.

(c) Within 30 calendar days after receiving notice of a change affecting the applicant or the application, the department shall advise the applicant:

(1) Whether additional information is required to process the pending application.

(2) Whether an additional application fee is required.

(3) Whether a new application and application fee must be submitted. The new application fee shall be twice the actual cost of additional review time caused by the change. This additional fee is payable to the department on demand.

(d) The department shall suspend the applicant's application and, if applicable, its permit to accept deposits if the applicant fails to give written notice of changes required by this section. The suspension shall remain in effect until the department has both assessed the potential impact of the changes on the interests of depositors and taken such action as necessary under this chapter to protect these interests.

SEC. 30. Section 1779.10 of the Health and Safety Code is amended to read:

1779.10. (a) The department shall deny an application for a permit to accept deposits and a certificate of authority if the applicant fails to do any of the following:

(1) Pay the application fee as required by Section 1779.2.

(2) Submit all information required by this chapter.

(3) Submit evidence to support a reasonable belief that any interested party of the proposed continuing care retirement community who has committed any offenses listed in subdivision (k)

of Section 1779.4 is of such good character as to indicate rehabilitation.

(4) Submit evidence to support a reasonable belief that the applicant is capable of administering the continuing care retirement community in compliance with applicable laws and regulations when an action specified in subdivision (j) or (k) of Section 1779.4 has been taken against the applicant.

(5) Demonstrate the feasibility of the proposed continuing care retirement community.

(6) Comply with residential care facility for the elderly licensing requirements.

(b) If the application is denied, no portion of the paid application fee shall be refundable or refunded.

(c) Immediately upon the denial of an application, the department shall notify the applicant in writing.

(d) The Notice of Denial from the department shall contain all of the following:

(1) A statement that the application is denied.

(2) The grounds for the denial.

(3) A statement informing the applicant that it has the right to appeal.

(4) A statement that the applicant has 30 calendar days from the date that the Notice of Denial was mailed to appeal the denial, and where to send the appeal.

(e) If the applicant appeals the denial, further proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 31. Section 1780 of the Health and Safety Code is amended to read:

1780. The department shall issue a permit to accept deposits when it has done all of the following:

(a) Determined that the application is adequate.

(b) Determined that the proposed continuing care retirement community financial and marketing studies are acceptable.

(c) Reviewed and approved the deposit agreements.

(d) Reviewed and approved the deposit escrow account agreement.

SEC. 32. Section 1780.2 of the Health and Safety Code is amended to read:

1780.2. (a) A deposit may be paid in one or several payments, at or after the time the parties enter into the deposit agreement.

A deposit shall be paid by cash or cash equivalent, jointly payable to the applicant and the escrow agent or depository. Possession and control of any deposit agreement shall be transferred to the escrow agent at the time the deposit is paid.

(b) A processing fee may be added to the deposit.

(1) The processing fee shall not exceed 1 percent of the amount of the average entrance fee or five hundred dollars ($500), whichever is greater.

(2) A nonrefundable processing fee may be paid directly to the applicant without being placed in the deposit escrow account.

(c) Payments made by a depositor for upgrades or modifications to the living unit shall not be placed in escrow with deposits. The applicant shall provide written refund policies to the depositor before accepting any payments for modifications or upgrades.

(d) The applicant shall furnish to the department within the first 10 days of each calendar month a list of all residents who have made payments for modifications or upgrades, the amounts each resident has paid, the date of each payment, and the unit to be modified or upgraded for each resident.

(e) All payments for modifications or upgrades shall be refunded to the depositor with interest if the applicant does not receive a certificate of authority for the proposed continuing care retirement community or expansion.

(f) The department may record a lien against the continuing care retirement community property, or any portion of the continuing care retirement community property, to secure the applicant's obligations to refund the depositor's payments made for modifications or upgrades. Any lien created under this section shall be to protect depositors and shall be governed by Section 1793.15.

SEC. 33. Section 1780.4 of the Health and Safety Code is amended to read:

1780.4. (a) All deposit agreements between the applicant and the depositor shall be in writing and shall contain all information required by this section.

(b) All deposit agreement forms shall be approved by the department prior to their use.

(c) The requirements of this chapter and Chapter 3.2 (commencing with Section 1569) shall be the bases for approval of the forms by the department.

(d) All text in deposit agreement forms shall be printed in at least 10-point typeface.

(e) The deposit agreement form shall provide all of the following:

(1) An estimated date for commencement of construction of the proposed continuing care retirement community or, if applicable, each phase not to exceed 36 months from the date the permit to accept deposits is issued.

(2) A statement to the effect that the applicant will notify depositors of any material change in the application.

(3) The identity of the specific unit reserved and the total deposit for that unit.

(4) Processing fee terms and conditions, including:

(A) The amount.

(B) A statement explaining the applicant's policy regarding refund or retention of the processing fee in the event of death of the depositor or voluntary cancellation by the depositor.

(C) Notice that the processing fee shall be refunded within 30 days if the applicant does not accept the depositor for residency, or the applicant fails to construct the continuing care retirement community before the estimated date of completion and the department determines that there is no satisfactory cause for the delay.

(5) Requirements for payment of the deposit by the depositor.

(6) A statement informing the depositor that their deposit payments will be converted to an entrance fee payment at the time the continuing care contract is executed.

(7) A statement informing the depositor that deposits shall be refunded within 30 calendar days of the depositor's nonacceptance for residency or notice to the applicant of the death of the depositor.

(8) A statement informing the depositor that all deposits shall be refunded to the depositors if the continuing care retirement community is not constructed by the estimated date of completion and the department determines that there is no satisfactory cause for the delay.

(9) A statement informing the depositor that a refund of the deposit within 10 calendar days of notice of cancellation by the depositor. The deposit agreement shall state that depositors who have deposited more than one thousand dollars ($1,000) or 5 percent of the entrance fee, whichever is greater, and who have been notified that construction of the proposed continuing care retirement community has commenced, will not be entitled to a refund of their deposit until the provisional certificate of authority is issued or after one of the following occurs:

(A) Another depositor has reserved the canceling depositor's specific residential unit and paid the necessary deposit.

(B) The depositor no longer meets financial or health requirements for admission.

(C) The applicant fails to meet the requirements of Section 1786 or 1786.2.

(10) A statement to depositors that specifies when funds may be released from escrow to the applicant and explains that thereafter the depositor's funds will not have escrow protection.

(11) A statement advising the depositor whether interest will be paid to the depositor on deposits placed in the deposit escrow account.

(f) If cash equivalents are to be accepted in lieu of cash, all of the following shall also be included in the deposit agreement:

(1) A statement that cash equivalents that may be accepted as deposits shall be either certificates of deposit or United States securities with maturities of five years or less.

(2) A statement that the instruments will be held by the escrow agent in the form in which they were delivered and assigned by the depositor until they are replaced by cash or converted to cash.

(3) A statement that the depositor will be required to assign the instruments to a neutral third-party escrow agent. If the bank or entity that issued the instruments refuses to allow this assignment, the escrow agent shall not accept the instruments. These instruments shall be reassigned to the depositor if the depositor terminates the deposit agreement before the instruments mature. If the depositor terminates the deposit agreement after the instruments mature, the depositor shall receive a cash refund of the portion of the deposit represented by the matured instruments.

(4) A statement that any amount by which the face value of the deposited instruments exceeds the required deposit shall be deemed part of the deposit and shall be applied against the depositor's obligations under the deposit agreement.

(5) A statement that the instruments shall be converted to, or replaced with, cash prior to the department's authorization for the release of deposits to the applicant. The depositor shall be advised that if the depositor does not substitute cash in the amount equal to the deposit, the applicant may do either of the following:

(A) Direct the escrow agent to sell, redeem, or otherwise convert the instruments to cash and to treat the proceeds in the same manner as it treats cash deposits under the deposit agreement. The costs of any such sale, redemption, or conversion, including, without limitation, transaction fees and any early withdrawal penalties, may be charged to the depositor and paid out of the cash or other instruments received from the depositor in escrow. If there is a shortfall, the depositor may be immediately obligated to pay the shortfall by check jointly payable to the applicant and the escrow agent.

(B) Terminate the deposit agreement. In this event, the escrow agent shall reassign the property to the depositor and refund all cash in escrow within the time periods specified in the deposit agreement.

(g) A statement that deposits will be invested in instruments guaranteed by the federal government or an agency of the federal government, or in investment funds secured by federally guaranteed instruments.

(h) A statement that no funds deposited in a deposit escrow account shall be subject to any liens, judgments, garnishments, or creditor's claims against the applicant, the proposed continuing care retirement community property, or the continuing care retirement community. The deposit agreement shall also provide that deposits may not be subject to any liens or charges by the escrow agent, except that cash equivalent deposits may be subject to transactions fees, commissions, prepayment penalties, and other fees incurred in connection with these deposits.

(i) A schedule of projected monthly care fees estimated to be charged to residents for each of the first five years of the continuing care retirement community's existence shall be attached to each deposit agreement. This schedule shall contain a conspicuous statement in at least 10-point boldface type that the projected fees are an estimate only and may be changed without notice.

SEC. 34. Section 1781 of the Health and Safety Code is amended to read:

1781. (a) All deposits, excluding processing fees, shall be placed in an escrow account. All terms governing the deposit escrow account shall be approved in advance by the department.

(b) The deposit escrow account shall be established by an escrow agent and all deposits shall be deposited in a depository located in California and approved by the department. The department's approval of the depository shall be based, in part, upon its ability to ensure the safety of funds and properties entrusted to it and its qualifications to perform the obligations of the depository pursuant to the deposit escrow account agreement and this chapter. The depository may be the same entity as the escrow agent. All deposits shall be kept and maintained in a segregated account without any commingling with other funds, including any funds or accounts owned by the applicant.

(c) If the escrow agent is a title company, it shall meet the following requirements:

(1) A Standard and Poors rating of ''A'' or better or a comparable rating from a comparable rating service.

(2) Licensure in good standing with the Department of Insurance.

(3) Tangible net equity as required by the Department of Insurance.

(4) Reserves as required by the Department of Insurance.

(d) All deposits shall remain in escrow until the department has authorized release of the deposits, as provided in Section 1783.3.

(e) Deposits shall be invested in instruments guaranteed by the federal government or an agency of the federal government, or in investment funds secured by federally guaranteed instruments.

(f) No funds deposited in a deposit escrow account shall be subject to any liens, judgments, garnishments, or creditor's claims against the applicant or the continuing care retirement community. The deposit agreement shall also provide that deposits may not be subject to any liens or charges by the escrow agent except that cash equivalent deposits may be subject to transaction fees, commissions, prepayment penalties, and other fees incurred in connection with those deposits.

SEC. 35. Section 1781.2 of the Health and Safety Code is amended to read:

1781.2. (a) All deposits shall be delivered to the escrow agent and deposited into the deposit escrow account within five business days

after receipt by the applicant. The deposit escrow account shall be accounted for in a separate escrow account.

(b) The applicant shall provide, with all deposits delivered to the escrow holder, a copy of the executed deposit agreement, a copy of the receipt given to the depositor, a summary of all deposits made on that date, and any other materials required by the escrow holder.

SEC. 36. Section 1781.4 of the Health and Safety Code is amended to read:

1781.4. The deposit escrow account agreement between the applicant and the escrow agent shall include all of the following:

(a) The amount of the processing fee.

(b) A provision requiring that all deposits shall be placed into the deposit escrow account upon delivery.

(c) A provision requiring that monthly progress reports be sent by the escrow agent directly to the department, beginning the month after the deposit escrow account is opened and continuing through the month funds are released from escrow. These reports shall be prepared every month that there are any funds in the account and shall show each of the following in separate columns:

(1) The name and address of each depositor or resident.

(2) The designation of the living unit being provided.

(3) Any processing fee which is deposited into escrow.

(4) The total deposit required for the unit.

(5) The total entrance fee for the unit.

(6) Twenty percent of the total entrance fee.

(7) Each deposit payment made by or on behalf of the depositor and any refunds paid to the depositor.

(8) The unpaid balance for each depositor's deposit.

(9) The unpaid balance for each depositor's entrance fee.

(10) The current balance in the deposit escrow account for each depositor and the collective balance.

(11) The dollar amount, type, and maturity date of any cash equivalent paid by each depositor.

(d) A provision for investment of escrow account funds in a manner consistent with Section 1781.

(e) A provision for refunds to depositors in the manner specified by Section 1783.2.

(f) A provision regarding the payment of interest earned on the funds held in escrow in the manner specified in the applicant's deposit agreement.

(g) Release of deposit escrow account funds in the manner specified in Section 1783.3, including to whom payment of interest earned on the funds will be made.

(h) Representations by the escrow agent that it is not, and shall not be during the term of the deposit escrow account, a lender to the applicant or for the proposed continuing care retirement community, or a fiduciary for any lender or bondholder for that

continuing care retirement community, unless approved by the department.

(i) If cash equivalents may be accepted as a deposit in lieu of cash, the deposit escrow account agreement shall also include all of the following:

(1) Authorization for the escrow agent to convert instruments to cash when they mature. The escrow agent may notify all financial institutions whose securities are held by the escrow agent that all interest and other payments due upon these instruments shall be paid to the escrow agent. The escrow agent shall collect, hold, invest, and disburse these funds as provided under the escrow agreement.

(2) Authorization for the escrow agent to deliver the instruments in its possession and release funds from escrow according to written directions from the applicant, consistent with the terms provided in the applicant's deposit escrow account agreement. The escrow agent shall distribute cash and other property to an individual depositor only upon either of the following occurrences:

(A) The depositor's written request to receive monthly payments of interest accrued on his or her deposits.

(B) Receipt of notice from the applicant to pay a refund to the depositor.

(3) A provision that the escrow agent shall maintain, at all times, adequate records showing the beneficial ownership of the instruments.

(4) A provision that the escrow agent shall have no responsibility or authority to initiate any transfer of the instruments or conduct any other transaction without specific written instructions from the applicant.

(5) A provision authorizing, instructing, and directing the escrow agent to do all of the following:

(A) Redeem and roll over matured investments into money market accounts or other department approved instruments with the escrow agent or an outside financial institution.

(B) Collect and receive interest, principal, and other things of value in connection with the instruments.

(C) Sign for the depositors any declarations, affidavits, certificates, and other documents that may be required to collect or receive payments or distributions with respect to the instruments.

SEC. 37. Section 1781.6 of the Health and Safety Code is amended to read:

1781.6. All changes to a deposit agreement or deposit escrow account agreement form shall be submitted to, and approved by, the department before use by the applicant.

SEC. 38. Section 1781.8 of the Health and Safety Code is amended to read:

1781.8. (a) Deposits held in escrow shall be placed in an interest bearing account or invested as provided under subdivision (e) of Section 1781.

(b) Interest, income, and other gains derived from deposits held in a deposit escrow account may not be released or distributed from the deposit escrow account except upon written approval of the department.

(c) Approval by the department for the release of earnings generated from funds held in escrow shall be based upon an assessment that funds remaining in the deposit escrow account will be sufficient to pay refunds and any interest promised to all depositors, as well as administrative costs owed to the escrow agent.

(d) When released by the department, interest earned by the funds in the deposit escrow account shall be distributed in accordance with the terms of the deposit agreement.

SEC. 39. Section 1781.10 of the Health and Safety Code is amended to read:

1781.10. No deposit or any other asset held in a deposit escrow account, shall be encumbered or used as collateral for any obligation of the applicant or any other person, unless the applicant obtains prior written approval from the department for the encumbrance or use as collateral. The department shall not approve any encumbrance or use as collateral under this section unless the encumbrance or use as collateral is expressly subordinated to the rights of depositors under this chapter to refunds of their deposits.

SEC. 40. Section 1782 of the Health and Safety Code is amended to read:

1782. (a) An applicant shall not begin construction on any phase of a continuing care retirement community without first obtaining a written acknowledgment from the department that all of the following prerequisites have been met:

(1) A completed application has been submitted to the department.

(2) A permit to accept deposits has been issued to the applicant or, in the case of continuing care retirement community renovation projects, the department has issued a written approval of the applicant's application.

(3) For new continuing care retirement communities, or construction projects adding new units to an existing continuing care retirement community, deposits equal to at least 20 percent of each depositor's applicable entrance fee have been placed into escrow for each phase for at least 50 percent of the number of residential living units to be constructed.

(b) Applicants shall notify depositors in writing when construction is commenced.

(c) For purposes of this chapter only, construction shall not include site preparation, demolition, or the construction of model units.

SEC. 41. Section 1783 of the Health and Safety Code is amended to read:

1783. (a) (1) An applicant proposing to convert an existing building to continuing care use shall comply with all the application requirements in Section 1779.4 identified by the department as necessary for the department to assess the feasibility of the proposed continuing care retirement community or conversion.

(2) If the proposed continuing care retirement community is already occupied and only a portion of the existing residential units will be converted into continuing care units, the department may modify the presale requirements of paragraph (3) of subdivision (a) of Section 1782 and paragraph (2) of subdivision (a) of Section 1783.3.

(b) Any applicant proposing to convert an existing building into continuing care units shall indicate the portion of the facility to be used for continuing care contract services. The continuing care allocation specified by the applicant shall be reflected in all financial and marketing studies and shall be used to determine the applicant's compliance with the percentage requirements stated in paragraph (3) of subdivision (a) of Section 1782 and paragraph (2) of subdivision (a) of Section 1783.3.

SEC. 42. Section 1783.2 of the Health and Safety Code is amended to read:

1783.2. (a) An escrow agent shall refund to the depositor all amounts required by the depositor's deposit agreement upon receiving written notice from the applicant that a depositor has canceled the deposit agreement. Refunds required by this subdivision shall be paid to the depositor within 10 days after the depositor gives notice of cancellation to the applicant.

(b) Depositors who have deposited more than one thousand dollars ($1,000) or 5 percent of the entrance fee, whichever is greater, and who have been notified that construction of the proposed continuing care retirement community has commenced, shall not be entitled to a refund of their deposit until any of the following occurs:

(1) The continuing care retirement community is opened for operation.

(2) Another depositor has reserved the canceling depositor's specific residential unit and paid the necessary deposit.

(3) The depositor no longer meets financial or health requirements for admission.

SEC. 43. Section 1783.3 is added to the Health and Safety Code, to read:

1783.3. (a) In order to seek a release of escrowed funds, the applicant shall petition in writing to the department and certify to each of the following:

(1) The construction of the proposed continuing care retirement community or phase is at least 50 percent completed.

(2) At least 20 percent of the total of each applicable entrance fee has been received and placed in escrow for at least 60 percent of the total number of residential living units. Any unit for which a refund is pending may not be counted toward that 60-percent requirement.

(3) Deposits made with cash equivalents have been either converted into, or substituted with, cash or held for transfer to the provider. A cash equivalent deposit may be held for transfer to the provider, if all of the following conditions exist:

(A) Conversion of the cash equivalent instrument would result in a penalty or other substantial detriment to the depositor.

(B) The provider and the depositor have a written agreement stating that the cash equivalent will be transferred to the provider, without conversion into cash, when the deposit escrow is released to the provider under this section.

(C) The depositor is credited the amount equal to the value of the cash equivalent.

(4) The applicant's average performance over any six-month period substantially equals or exceeds its financial and marketing projections approved by the department, for that period.

(5) The applicant has received a commitment for any permanent mortgage loan or other long-term financing.

(b) The department shall instruct the escrow agent to release to the applicant all deposits in the deposit escrow account when all of the following requirements have been met:

(1) The department has confirmed the information provided by the applicant pursuant to subdivision (a).

(2) The department, in consultation with the Continuing Care Advisory Committee, has determined that there has been substantial compliance with projected annual financial statements that served as a basis for issuance of the permit to accept deposits.

(3) The applicant has complied with all applicable licensing requirements in a timely manner.

(4) The applicant has obtained a commitment for any permanent mortgage loan or other long-term financing that is satisfactory to the department.

(5) The applicant has complied with any additional reasonable requirements for release of funds placed in the deposit escrow accounts, established by the department under Section 1785.

(c) The escrow agent shall release the funds held in escrow to the applicant only when the department has instructed it to do so in writing.

(d) When an application describes different phases of construction that will be completed and commence operating at different times, the department may apply the 50 percent construction completion requirement to any one or group of phases requested by the applicant, provided the phase or group of phases is shown in the applicant's projections to be economically viable.

SEC. 44. Section 1784 of the Health and Safety Code is amended to read:

1784. (a) If construction of the proposed continuing care retirement community, or applicable phase, has not commenced within 36 months from the date the permit to accept deposits is issued, an applicant may request an extension of the permit to accept deposits. The request for extension shall be made to the department in writing and shall include the reasons why construction of the proposed continuing care retirement community was not commenced within the required 36-month period. The request for extension shall also state the new estimated date for commencement of construction.

(b) In response to a request for an extension, the department may do one of the following:

(1) If the department determines there is satisfactory cause for the delay in commencement of construction of the proposed continuing care retirement community or applicable phase, the department may extend the permit to accept deposits for up to one year.

(2) If the department determines that there is no satisfactory cause for the delay, the department may instruct the escrow agent to refund to depositors all deposits held in escrow, plus any interest due under the terms of the deposit subscription agreements, and require the applicant to file a new application and application fee. The applicant shall also refund all processing fees paid by the depositors.

(c) Within 10 calendar days the applicant shall notify each depositor of the department's approval or denial of the extension, of any expiration of the permit to accept deposits and of any right to a refund of their deposits.

SEC. 45. Section 1785 of the Health and Safety Code is amended to read:

1785. (a) If, at any time prior to issuance of a certificate of authority, the applicant's average performance over any six-month period does not substantially equal or exceed the applicant's projections for that period, the department, after consultation and upon consideration of the recommendations of the Continuing Care Advisory Committee, may take any of the following actions:

(1) Cancel the permit to accept deposits and require that all funds in escrow be returned to depositors immediately.

(2) Increase the required percentages of construction completed, units reserved, or entrance fees to be deposited as required under Sections 1782, 1783.3, 1786, and 1786.2.

(3) Increase the reserve requirements under this chapter.

(b) Prior to taking any actions specified in subdivision (a), the department shall give the applicant an opportunity to submit a feasibility study from a consultant in the area of continuing care, approved by the department, to determine whether in his or her opinion the proposed continuing care retirement community is still viable, and if so, to submit a plan of correction. The department, in consultation with the committee, shall determine if the plan is acceptable.

(c) In making its determination, the department shall take into consideration the overall performance of the proposed continuing care retirement community to date.

(d) If deposits have been released from escrow, the department may further require the applicant to reopen the escrow as a condition of receiving any further entrance fee payments from depositors or residents.

(e) The department may require the applicant to notify all depositors and, if applicable, all residents, of any actions required by the department under this section.

SEC. 46. Section 1786 of the Health and Safety Code is amended to read:

1786. (a) The department shall issue a provisional certificate of authority when an applicant has done all of the following:

(1) Complied with the approved marketing plans.

(2) Met and continues to meet the requirements imposed under subdivision (a) of Section 1783.3. The issuance of the provisional certificate of authority shall not require, and shall not be dependent upon the release of escrowed funds. Release of escrowed funds shall be governed by Section 1783.3.

(3) Completed construction of the continuing care retirement community or applicable phase.

(4) Obtained the required licenses.

(5) Paid the remainder of the application fee.

(6) Executed a permanent mortgage loan or other long-term financing.

(7) Provided the department with a recorded copy of the Notice of Statutory Limitation on Transfer required by subdivision (aa) of Section 1779.4.

(8) Met all applicable provisions of this chapter.

(b) The provisional certificate of authority shall expire 12 months after issuance unless both of the following occur:

(1) No later than 60 days prior to the expiration of the provisional certificate of authority, the provider petitions the department and

demonstrates good cause in writing for an extension of the provisional certificate of authority.

(2) The department determines that the provider is capable of meeting the requirements of Section 1786.2 during the extension period.

(c) The department shall exercise its discretion to determine the length of the extension period.

(d) After the provisional certificate of authority is issued providers may continue to take deposits by modifying the deposit agreement as appropriate. The new deposit agreement shall clearly state the rights of the depositor and the provider. The applicant shall submit the agreements to the department for review and approval prior to use. A provider that holds a provisional certificate of authority or certificate of authority may accept fees paid by potential residents to be placed on a waiting list without using a deposit agreement. These waiting list fees may not exceed five hundred dollars ($500), and shall be refunded to the potential resident upon written request.

(e) All holders of a provisional certificate of authority shall request in writing a certificate of authority when the requirements of Section 1786.2 have been met.

SEC. 47. Section 1786.2 of the Health and Safety Code is amended to read:

1786.2. (a) The department shall not issue a certificate of authority to an applicant or a provider, until the department determines that each of the following has occurred:

(1) A provisional certificate of authority has been issued or all of the requirements for a provisional certificate of authority have been satisfied. In the case of an application for a new certificate of authority due to an organizational change, if the continuing care retirement community is financially sound and operating in compliance with this chapter, it shall be sufficient for the purposes of this paragraph that the department has approved the application in writing.

(2) One of the following requirements has been met:

(A) At a minimum, continuing care contracts have been executed for 80 percent of the total residential living units in the continuing care retirement community, with payment in full of the entrance fee.

(B) At a minimum, continuing care contracts have been executed for 70 percent of the total residential living units in the continuing care retirement community, with payment in full of the entrance fee, and the provider has submitted an updated financial and marketing plan, satisfactory to the department, demonstrating that the proposed continuing care retirement community will be financially viable.

(C) At a minimum, continuing care contracts have been executed for 50 percent of the total residential living units in the continuing care retirement community, with payment in full of the entrance fee,

and the provider furnishes and maintains a letter of credit or other security, satisfactory to the department, sufficient to bring the total amount of payments to a level equivalent to 80 percent of the total entrance fees for the entire continuing care retirement community.

(3) A minimum five-year financial plan of operation remains satisfactory to the department.

(4) Adequate reserves exist as required by Sections 1792 and 1792.6. For a new continuing care retirement community without an operating history, the department may approve calculation of required reserves on a pro forma basis in conjunction with compliance with approved marketing plans.

(5) All applicable provisions of this chapter have been met.

(b) When issued, the certificate of authority, whether full or conditioned, shall remain in full force unless forfeited by operation of law under Section 1793.7, inactivated under Section 1793.8, or suspended or revoked by the department pursuant to Section 1793.21.

(c) The provider shall display the certificate of authority in a prominent place within the continuing care retirement community.

SEC. 48. Section 1787 of the Health and Safety Code is amended to read:

1787. (a) All continuing care contracts shall be in writing and shall contain all the information required by Section 1788.

(b) All continuing care contract forms, including all addenda, exhibits, and any other related documents, incorporated therein, as well as any modification to these items, shall be approved by the department prior to their use.

(c) The department shall approve continuing care contract forms that comply with this chapter. The requirements of this chapter and Chapter 3.2 (commencing with Section 1569) shall be the bases for approval by the department. To the extent that this chapter conflicts with Chapter 3.2 (commencing with Section 1569), this chapter shall prevail.

(d) A continuing care contract approved by the department shall constitute the full and complete agreement between the parties.

(e) More than one continuing care contract form may be used by a provider if multiple program options are available.

(f) All text in continuing care contract forms shall be printed in at least 10-point typeface.

(g) A clearly legible copy of the continuing care contract, executed by each provider named on the provisional certificate of authority or the certificate of authority, the resident, and any transferor, shall be furnished with all required or included attachments to the resident at the time the continuing care contract is executed. A copy shall also be furnished within 10 calendar days to any transferor who is not a resident.

(h) The provider shall require a written acknowledgment from the resident (and any transferor who is not a resident) that the executed copy of the continuing care contract and attachments have been received.

(i) The continuing care contract shall be an admissions agreement for purposes of the residential care facility for the elderly and long-term health care facility requirements and shall state the resident's entitlement to receive these levels of care. The continuing care contract may state the entitlement for skilled nursing care in accordance with the provisions of law governing admissions to long-term health care facilities in effect at the time of admission to the skilled nursing facility. The parties may agree to the terms of nursing facility admission at the time the continuing care contract is executed, or the provider may present an exemplar of the then-current nursing facility admission agreement and require the resident to execute the form of agreement in effect at the time of admission to the nursing facility. The terms shall include the nursing fee, or the method of determining the fee, at the time of the execution of the continuing care contract, the services included in and excluded from the fee, the grounds for transfers and discharges, and any other terms required to be included under applicable law.

(j) Only the skilled nursing admission agreement sections of continuing care contracts which cover long-term health care facility services are subject to Chapter 3.95 (commencing with Section 1599.60). The provider shall use a skilled nursing admission nursing agreement that complies with the requirements of Chapter 3.95 (commencing with Section 1599.85).

SEC. 49. Section 1788 of the Health and Safety Code is amended to read:

1788. (a) Any continuing care contracts shall contain all of the following:

(1) The legal name and address of each provider.

(2) The name and address of the continuing care retirement community.

(3) The resident's name and the identity of the unit the resident will occupy.

(4) If there is a transferor other than the resident, the transferor shall be a party to the contract and the transferor's name and address shall be specified.

(5) If the provider has used the name of any charitable or religious or nonprofit organization in its title before January 1, 1979, and continues to use that name, and that organization is not responsible for the financial and contractual obligations of the provider or the obligations specified in the continuing care contract, the provider shall include in every continuing care contract a conspicuous statement which clearly informs the resident that the organization is not financially responsible.

(6) The date the continuing care contract is signed by the resident and, where applicable, any other transferor.

(7) The duration of the continuing care contract.

(8) A list of the services that will be made available to the resident as required to provide the appropriate level of care. The list of services shall include the services required as a condition for licensure as a residential care facility for the elderly, including all of the following:

(A) Regular observation of the resident's health status to ensure that his or her dietary needs, social needs, and needs for special services are satisfied.

(B) Safe and healthful living accommodations, including housekeeping services and utilities.

(C) Maintenance of house rules for the protection of residents.

(D) A planned activities program, which includes social and recreational activities appropriate to the interests and capabilities of the resident.

(E) Three balanced, nutritious meals and snacks made available daily, including special diets prescribed by a physician as a medical necessity.

(F) Assisted living services.

(G) Assistance with taking medications.

(H) Central storing and distribution of medications.

(I) Arrangements to meet health needs, including arranging transportation.

(9) An itemization of the services that are included in the monthly fee and the services that are available at an extra charge. The provider shall attach a current fee schedule to the continuing care contract.

(10) The procedures and conditions under which residents may be voluntarily and involuntarily transferred from their designated living units. The transfer procedures, at a minimum, shall include provisions addressing all of the following circumstances under which transfer may be authorized:

(A) When, in the opinion of the continuing care retirement community management, a physician, appropriate specialist, or licensing official in consultation with the resident and appropriate representative, if any, any of the following conditions exists:

(i) The resident is nonambulatory. The definition of ''nonambulatory,'' as provided in Section 13131, shall either be stated in full in the continuing care contract or be cited. If Section 13131 is cited, a copy of the statute shall be made available to the resident, either as an attachment to the continuing care contract or by specifying that it will be provided upon request. If a nonambulatory resident occupies a room that has a fire clearance for nonambulatory residence, transfer shall not be necessary.

(ii) The resident develops a physical or mental condition that endangers the health, safety, or well-being of the resident or another person, or causes an unreasonable and ongoing disturbance at the continuing care retirement community.

(iii) The resident's condition or needs require the resident's transfer to an assisted living care unit or skilled nursing facility for more efficient care or to protect the health of other residents, or because the level of care required by the resident exceeds that which may be lawfully provided in the living unit.

(iv) The resident's condition or needs require the resident's transfer to a nursing facility, hospital, or other facility, and the provider has no facilities available to provide that level of care.

(B) Transfer of a second resident when a shared accommodation arrangement is terminated.

(C) Transfer is requested or required, by the provider or the resident, for any other reason.

(11) Provisions describing any changes in the resident's monthly fee and any changes in the entrance fee refund payable to the resident that will occur if the resident transfers from any unit.

(12) The provider's continuing obligations if any, in the event a resident is transferred from the continuing care retirement community to another facility.

(13) The provider's obligations, if any, to resume care upon the resident's return after a transfer from the continuing care retirement community.

(14) The provider's obligations to provide services to the resident while the resident is absent from the continuing care retirement community.

(15) The conditions under which the resident must permanently release his or her living unit.

(16) If real or personal properties are transferred in lieu of cash, a statement specifying each item's value at the time of transfer, and how the value was ascertained.

(A) An itemized receipt which includes the information described above is acceptable if incorporated as a part of the continuing care contract.

(B) When real property is or will be transferred, the continuing care contract shall include a statement that the deed or other instrument of conveyance shall specify that the real property is conveyed pursuant to a continuing care contract and may be subject to rescission by the transferor within 90 days from the date that the resident first occupies the residential unit.

(C) The failure to comply with paragraph (16) shall not affect the validity of title to real property transferred pursuant to this chapter.

(17) The amount of the entrance fee.

(18) In the event two parties have jointly paid the entrance fee or other payment which allows them to occupy the unit, the continuing

care contract shall describe how any refund of entrance fees is allocated.

(19) The amount of any processing fee.

(20) The amount of any monthly care fee.

(21) For continuing care contracts that require a monthly care fee or other periodic payment, the continuing care contract shall include the following:

(A) A statement that the occupancy and use of the accommodations by the resident is contingent upon the regular payment of the fee.

(B) The regular rate of payment agreed upon (per day, week, or month).

(C) A provision specifying whether payment will be made in advance or after services have been provided.

(D) A provision specifying the provider will adjust monthly care fees for the resident's support, maintenance, board, or lodging, when a resident requires medical attention while away from the continuing care retirement community.

(E) A provision specifying whether a credit or allowance will be given to a resident who is absent from the continuing care retirement community or from meals. This provision shall also state, when applicable, that the credit may be permitted at the discretion or by special permission of the provider.

(22) All continuing care contracts that include monthly care fees shall address changes in monthly care fees by including either of the following provisions:

(A) For prepaid continuing care contracts, which include monthly care fees, one of the following methods:

(i) Fees shall not be subject to change during the lifetime of the agreement.

(ii) Fees shall not be increased by more than a specified number of dollars in any one year and not more than a specified number of dollars during the lifetime of the agreement.

(iii) Fees shall not be increased in excess of a specified percentage over the preceding year and not more than a specified percentage during the lifetime of the agreement.

(B) For monthly fee continuing care contracts, except prepaid contracts, changes in monthly care fees shall be based on projected costs, prior year per capita costs, and economic indicators.

(23) A provision requiring that the provider give written notice to the resident at least 30 days in advance of any change in the resident's monthly care fees or in the price or scope of any component of care or other services.

(24) A provision indicating whether the resident's rights under the continuing care contract include any proprietary interests in the assets of the provider or in the continuing care retirement community, or both.

(25) If the continuing care retirement community property is encumbered by a security interest that is senior to any claims the residents may have to enforce continuing care contracts, a provision shall advise the residents that any claims they may have under the continuing care contract are subordinate to the rights of the secured lender. For equity projects, the continuing care contract shall specify the type and extent of the equity interest and whether any entity holds a security interest.

(26) Notice that the living units are part of a continuing care retirement community that is licensed as a residential care facility for the elderly and, as a result, any duly authorized agent of the department may, upon proper identification and upon stating the purpose of his or her visit, enter and inspect the entire premises at any time, without advance notice.

(27) A conspicuous statement, in at least 10-point boldface type in immediate proximity to the space reserved for the signatures of the resident and, if applicable, the transferor, that provides as follows: ''You, the resident or transferor, may cancel the transaction without cause at any time within 90 days from the date you first occupy your living unit. See the attached notice of cancellation form for an explanation of this right.''

(28) Notice that during the cancellation period, the continuing care contract may be canceled upon 30 days' written notice by the provider without cause, or that the provider waives this right.

(29) The terms and conditions under which the continuing care contract may be terminated after the cancellation period by either party, including any health or financial conditions.

(30) A statement that, after the cancellation period, a provider may unilaterally terminate the continuing care contract only if the provider has good and sufficient cause.

(A) Any continuing care contract containing a clause that provides for a continuing care contract to be terminated for ''just cause,'' ''good cause,'' or other similar provision, shall also include a provision that none of the following activities by the resident, or on behalf of the resident, constitutes ''just cause,'' ''good cause,'' or otherwise activates the termination provision:

(i) Filing or lodging a formal complaint with the department or other appropriate authority.

(ii) Participation in an organization or affiliation of residents, or other similar lawful activity.

(B) The provision required by this paragraph shall also state that the provider shall not discriminate or retaliate in any manner against any resident of a continuing care retirement community for contacting the department, or any other state, county, or city agency, or any elected or appointed government official to file a complaint or for any other reason, or for participation in a residents' organization or association.

(C) Nothing in this paragraph diminishes the provider's ability to terminate the continuing care contract for good and sufficient cause.

(31) A statement that at least 90 days' written notice to the resident is required for a unilateral termination of the continuing care contract by the provider.

(32) A statement concerning the length of notice that a resident is required to give the provider to voluntarily terminate the continuing care contract after the cancellation period.

(33) The policy or terms for refunding any portion of the entrance fee, in the event of cancellation, termination, or death. Every continuing care contract that provides for a refund of all or a part of the entrance fee shall also do all of the following:

(A) Specify the amount, if any, the resident has paid or will pay for upgrades, special features, or modifications to the resident's unit.

(B) State that if the continuing care contract is cancelled or terminated by the provider, the provider shall do both of the following:

(i) Amortize the specified amount at the same rate as the resident's entrance fee.

(ii) Refund the unamortized balance to the resident at the same time the provider pays the resident's entrance fee refund.

(34) The following notice at the bottom of the signatory page:

''NOTICE'' (date)

This is a continuing care contract as defined by paragraph (8) of subdivision (c), or subdivision (*l*) of Section 1771 of the California Health and Safety Code. This continuing care contract form has been approved by the State Department of Social Services as required by subdivision (b) of Section 1787 of the California Health and Safety Code. The basis for this approval was a determination that (provider name) has submitted a contract that complies with the minimum statutory requirements applicable to continuing care contracts. The department does not approve or disapprove any of the financial or health care coverage provisions in this contract. Approval by the department is NOT a guaranty of performance or an endorsement of any continuing care contract provisions. Prospective transferors and residents are strongly encouraged to carefully consider the benefits and risks of this continuing care contract and to seek financial and legal advice before signing.

(35) The provider may not attempt to absolve itself in the continuing care contract from liability for its negligence by any statement to that effect, and shall include the following statement in the contract: ''Nothing in this continuing care contract limits either the provider's obligation to provide adequate care and supervision for the resident or any liability on the part of the provider which may

result from the provider's failure to provide this care and supervision.''

(b) A life care contract shall also provide that:

(1) All levels of care, including acute care and physicians' and surgeons' services will be provided to a resident.

(2) Care will be provided for the duration of the resident's life unless the life care contract is canceled or terminated by the provider during the cancellation period or after the cancellation period for good cause.

(3) A comprehensive continuum of care will be provided to the resident, including skilled nursing, in a facility under the ownership and supervision of the provider on, or adjacent to, the continuing care retirement community premises.

(4) Monthly care fees will not be changed based on the resident's level of care or service.

(5) A resident who becomes financially unable to pay his or her monthly care fees shall be subsidized provided the resident's financial need does not arise from action by the resident to divest the resident of his or her assets.

(c) Continuing care contracts may include provisions that do any of the following:

(1) Subsidize a resident who becomes financially unable to pay for his or her monthly care fees at some future date. If a continuing care contract provides for subsidizing a resident, it may also provide for any of the following:

(A) The resident shall apply for any public assistance or other aid for which he or she is eligible and that the provider may apply for assistance on behalf of the resident.

(B) The provider's decision shall be final and conclusive regarding any adjustments to be made or any action to be taken regarding any charitable consideration extended to any of its residents.

(C) The provider is entitled to payment for the actual costs of care out of any property acquired by the resident subsequent to any adjustment extended to the resident under paragraph (1), or from any other property of the resident which the resident failed to disclose.

(D) The provider may pay the monthly premium of the resident's health insurance coverage under Medicare to ensure that those payments will be made.

(E) The provider may receive an assignment from the resident of the right to apply for and to receive the benefits, for and on behalf of the resident.

(F) The provider is not responsible for the costs of furnishing the resident with any services, supplies, and medication, when reimbursement is reasonably available from any governmental agency, or any private insurance.

(G) Any refund due to the resident at the termination of the continuing care contract may be offset by any prior subsidy to the resident by the provider.

(2) Limit responsibility for costs associated with the treatment or medication of an ailment or illness existing prior to the date of admission. In these cases, the medical or surgical exceptions, as disclosed by the medical entrance examination, shall be listed in the continuing care contract or in a medical report attached to and made a part of the continuing care contract.

(3) Identify legal remedies which may be available to the provider if the resident makes any material misrepresentation or omission pertaining to the resident's assets or health.

(4) Restrict transfer or assignments of the resident's rights and privileges under a continuing care contract due to the personal nature of the continuing care contract.

(5) Protect the provider's ability to waive a resident's breach of the terms or provisions of the continuing care contract in specific instances without relinquishing its right to insist upon full compliance by the resident with all terms or provisions in the contract.

(6) Provide that the resident shall reimburse the provider for any uninsured loss or damage to the resident's unit, beyond normal wear and tear, resulting from the resident's carelessness or negligence.

(7) Provide that the resident agrees to observe the off-limit areas of the continuing care retirement community designated by the provider for safety reasons. The provider may not include any provision in a continuing care contract that absolves the provider from liability for its negligence.

(8) Provide for the subrogation to the provider of the resident's rights in the case of injury to a resident caused by the acts or omissions of a third party, or for the assignment of the resident's recovery or benefits in this case to the provider, to the extent of the value of the goods and services furnished by the provider to or on behalf of the resident as a result of the injury.

(9) Provide for a lien on any judgment, settlement, or recovery for any additional expense incurred by the provider in caring for the resident as a result of injury.

(10) Require the resident's cooperation and assistance in the diligent prosecution of any claim or action against any third party.

(11) Provide for the appointment of a conservator or guardian by a court with jurisdiction in the event a resident becomes unable to handle his or her personal or financial affairs.

(12) Allow a provider, whose property is tax exempt, to charge the resident on a pro rata basis property taxes, or in-lieu taxes, that the provider is required to pay.

(13) Make any other provision approved by the department.

(d) A copy of the resident's rights as described in Section 1771.7 shall be attached to every continuing care contract.

(e) A copy of the current audited financial statement of the provider shall be attached to every continuing care contract. For a provider whose current audited financial statement does not accurately reflect the financial ability of the provider to fulfill the continuing care contract obligations, the financial statement attached to the continuing care contract shall include all of the following:

(1) A disclosure that the reserve requirement has not yet been determined or met, and that entrance fees will not be held in escrow.

(2) A disclosure that the ability to provide the services promised in the continuing care contract will depend on successful compliance with the approved financial plan.

(3) A copy of the approved financial plan for meeting the reserve requirements.

(4) Any other supplemental statements or attachments necessary to accurately represent the provider's financial ability to fulfill its continuing care contract obligations.

(f) A schedule of the average monthly care fees charged to residents for each type of residential living unit for each of the five years preceding execution of the continuing care contract shall be attached to every continuing care contract. The provider shall update this schedule annually at the end of each fiscal year. If the continuing care retirement community has not been in existence for five years, the information shall be provided for each of the years the continuing care retirement community has been in existence.

(g) If any continuing care contract provides for a health insurance policy for the benefit of the resident, the provider shall attach to the continuing care contract a binder complying with Sections 382 and 382.5 of the Insurance Code.

(h) The provider shall attach to every continuing care contract a completed form in duplicate, captioned ''Notice of Cancellation.'' The notice shall be easily detachable, and shall contain, in at least 10-point boldface type, the following statement:

''NOTICE OF CANCELLATION'' (date)

Your first date of occupancy under this contract is: _____

''You may cancel this transaction, without any penalty within 90 calendar days from the above date.

If you cancel, any property transferred, any payments made by you under the contract, and any negotiable instrument executed by you will be returned within 14 calendar days after making possession of the living unit available to the provider. Any security interest arising out of the transaction will be canceled.

If you cancel, you are obligated to pay a reasonable processing fee to cover costs and to pay for the reasonable value of the services

received by you from the provider up to the date you canceled or made available to the provider the possession of any living unit delivered to you under this contract, whichever is later.

If you cancel, you must return possession of any living unit delivered to you under this contract to the provider in substantially the same condition as when you took possession.

Possession of the living unit must be made available to the provider within 20 calendar days of your notice of cancellation. If you fail to make the possession of any living unit available to the provider, then you remain liable for performance of all obligations under the contract.

To cancel this transaction, mail or deliver a signed and dated copy of this cancellation notice, or any other written notice, or send a telegram

to _____
(Name of provider)

at _____
(Address of provider's place of business)

not later than midnight of _____ (date).

I hereby cancel this transaction _____
(Resident or Transferor's signature)''

SEC. 50. Section 1788.2 of the Health and Safety Code is amended to read:

1788.2. (a) A continuing care contract may be canceled without cause by written notice from either party within 90 days from the date of the resident's initial occupancy.

(b) For all continuing care contracts, death of the resident before or during the cancellation period shall constitute a cancellation of the continuing care contract under subdivision (a), unless the continuing care contract includes specific provisions otherwise.

(c) The cancellation period and the associated refund obligations shall apply as follows:

(1) To all executed continuing care contracts regarding a unit in a continuing care retirement community that is not an equity continuing care retirement community.

(2) To continuing care contracts executed in conjunction with a purchase of an equity interest from a provider but not to continuing care contracts executed in conjunction with sales of an equity interest by one resident to another.

(d) The following fees may be charged before or during the 90-day cancellation period:

(1) If possession of the living unit in a continuing care retirement community that is not an equity continuing care retirement community is returned to the provider in substantially the same condition as when received, the resident's only obligations shall be to pay a reasonable fee to cover costs and to pay the reasonable value of services rendered pursuant to the canceled continuing care contract.

(2) Equity project providers may impose a resale fee on sellers. For contracts entered into after January 1, 1996, upon the cancellation of a continuing care contract executed in conjunction with the purchase of an equity interest from the provider, the provider may charge a resale fee not to exceed the excess of the gross resale price of the equity interest over the purchase price paid by the resident or on behalf of the resident for the interest.

(e) No resale fee shall exceed the sum of 10 percent of either the original or resale price of the equity interest and 100 percent of the excess if any, of the gross resale price of the equity interest over the purchase price paid by the resident or on behalf of the resident for the interest if either of the following applies:

(1) The continuing care contract involved the purchase of an equity interest from the provider and is terminated after the cancellation period.

(2) The continuing care contract involved the purchase of an equity interest from another resident and is terminated at any time.

(f) For purposes of this section, ''gross resale price'' means the resale price before any deductions for resale fees, transfer taxes, real estate commissions, periodic fees, late charges, interest, escrow fees, or any other fees incidental to the sale of real property.

(g) This section may not be construed to limit the provider's ability to withhold delinquent periodic fees, late charges, accrued interest, or assessments from the sale proceeds, as provided by the continuing care contract or the real estate documents governing the equity continuing care retirement community.

SEC. 51. Section 1788.4 of the Health and Safety Code is amended to read:

1788.4. (a) During the cancellation period, the provider shall pay all refunds owed to a resident within 14 calendar days after a resident makes possession of the living unit available to the provider.

(b) After the cancellation period, any refunds due to a resident under a continuing care contract shall be paid within 14 calendar days after a resident makes possession of the living unit available to the provider or 90 calendar days after death or receipt of notice of termination, whichever is later.

(c) In nonequity projects, if the continuing care contract is canceled by either party during the cancellation period or

terminated by the provider after the cancellation period, the resident shall be refunded the difference between the total amount of entrance, monthly, and optional fees paid and the amount used for care of the resident.

(d) If a resident has paid additional amounts for upgrades, special features, or modifications to the living unit and the provider terminates the resident's continuing care contract, the provider shall amortize those additional amounts at the same rate as the entrance fee and shall refund the unamortized balance to the resident.

(e) A lump-sum payment to a resident after termination of a continuing care contract that is conditioned upon resale of a unit shall not be considered to be a refund and may not be characterized or advertised as a refund. The lump sum payment shall be paid to the resident within 14 calendar days after resale of the unit.

SEC. 52. Section 1789 of the Health and Safety Code is amended to read:

1789. (a) A provider shall notify the department and obtain its approval before making any changes to any of the following: its name; its business structure or form of doing business; the overall management of its continuing care retirement community; or the terms of its financing.

(b) The provider shall give written notice of proposed changes to the department at least 60 calendar days in advance of making the changes described in this section.

(c) This notice requirement does not apply to routine facility staff changes.

(d) Within 10 calendar days of submitting notification to the department of any proposed changes under subdivision (a), the provider shall notify the resident association of the proposed changes in the manner required by subdivision (e) of Section 1779.

SEC. 53. Section 1789.1 is added to the Health and Safety Code, to read:

1789.1. (a) Before executing a deposit agreement or continuing care agreement, or receiving any payment from a depositor or prospective resident, a provider shall deliver to the other parties in the deposit or continuing care agreement a disclosure statement in the form prescribed by the department.

(b) The department shall issue a disclosure statement form that shall generally require disclosure, at a minimum, of the following information:

(1) General information regarding the provider and the continuing care retirement community, including at a minimum all of the following:

(A) The continuing care retirement community's name, address, and telephone number.

(B) The type of ownership, names of the continuing care retirement community's owner and operator, the names of any affiliated facilities, and any direct religious affiliation.

(C) Whether accredited and by what organization.

(D) The year the continuing care retirement community opened and the distance to the nearest shopping center and hospital.

(E) Whether the continuing care retirement community offers life care contracts or continuing care contracts, and whether the continuing care retirement community is single story or multistory.

(F) The number of the continuing care retirement community's studio units, one bedroom units, two bedroom units, cottages or houses, assisted living beds, and skilled nursing beds.

(G) The continuing care retirement community's percentage occupancy at the provider's most recent fiscal yearend.

(H) The form of contracts offered, the range of entrance fees, the percentages of a resident's entrance fees that may be refunded, and the health care benefits included in contract.

(I) Any age and insurance requirements for admission.

(J) A listing of common area amenities and other services included with the monthly service fee, and a listing of those amenities and services that are available for an additional charge.

(K) The number of meals each day included in the monthly service fee, the number of meals available for an extra charge, the frequency of housekeeping services, and additional cost, if any , for housekeeping services.

(2) Income from operations during the most recent five years for which audited financial statements have been completed, including all of the following:

(A) Operating income (excluding amortization of entrance fee income).

(B) Operating expense (excluding depreciation, amortization, and interest).

(C) Net income from operations.

(D) Interest expense.

(E) Unrestricted contributions.

(F) Nonoperating income or expense, excluding extraordinary items.

(G) Net income or loss before entrance fees.

(H) Net cash-flow from entrance fees, that is the total deposits less refunds.

(3) The name of the lender, outstanding balance, interest rate, date of origination, date of maturity, and amortization period for all secured debt.

(4) Financial ratios for each of the three most recent years for which audited financial statements have been prepared, including all of the following: debt-to-asset ratio, operating ratio, debt service coverage ratio, and days cash-on-hand. The formulas for each ratio

shall be determined by the department after consultation with the Continuing Care Advisory Committee.

(5) The average monthly service fees charged during the most recent five years, and the percentage changes in the average from year to year, for each of the following: studio units, one bedroom units, two bedroom units, cottages and houses, assisted living units, and skilled nursing units.

(6) Comments from the provider explaining any of the information included in the disclosure form.

(c) Each provider shall update its disclosure statement at least annually when it completes its annual audited financial statements. Each provider shall file its updated version of the disclosure statement with the department not later than the final filing date for its annual report.

(d) The form prescribed by the department under this section shall be used by providers to comply with the requirements of this section.

SEC. 54. Section 1789.2 of the Health and Safety Code is amended to read:

1789.2. (a) A provider shall provide the department with written notice at least 90 calendar days prior to closing any transaction that results in an encumbrance or lien on a continuing care retirement community property or its revenues.

(b) The written notice required by this section shall include all of the following:

(1) A description of the terms and amount of the proposed transaction.

(2) An analysis of the sources of funds for repayment of principal and interest.

(3) An analysis of the impact of the proposed transaction on monthly care fees.

(4) An analysis of the impact that the proposed encumbrance would have on assets available for liquid reserves required by Section 1792, and refund reserves required by Section 1792.6.

(c) Within seven calendar days of receipt of notice of proposed changes, the department shall acknowledge receipt of the notice in writing.

(d) Within 30 calendar days following its receipt of the notice, the department shall inform the provider in writing whether additional materials are required to evaluate the transaction.

(e) Within 90 calendar days following its receipt of additional materials, the department shall inform the provider of its approval or denial of the proposed transaction.

(f) Providers shall not execute the proposed financial transaction for which notice has been given pursuant to subdivision (a) without the department's written authorization unless either the 30-day response period or the 90 calendar day period for the department's

review of the provider's request has expired without any response by the department.

(g) If the department determines that the proposed financial transaction will materially increase monthly care fees or impair the provider's ability to maintain required reserves, the department may:

(1) Refuse to approve the transaction.

(2) Record a notice of lien on the provider's property pursuant to Section 1793.15 after notifying the provider and giving the provider an opportunity to withdraw the planned transaction.

(3) Take both actions and any other action that it determines is necessary to protect the best interests of the residents.

(h) Within 10 calendar days of submitting notification to the department of any proposed encumbrance to the community property, the provider shall notify the resident governing body or association of the proposed encumbrance in the manner required by subdivision (e) of Section 1779.

SEC. 55. Section 1789.4 of the Health and Safety Code is amended to read:

1789.4. (a) A provider for a continuing care retirement community shall obtain approval from the department before consummating any sale or transfer of the continuing care retirement community or any interest in that community, other than sale of an equity interest in a unit to a resident or other transferor.

(b) The provider shall provide written notice to the department at least 120 calendar days prior to consummating the proposed transaction.

(c) The notice required by this section shall include all of the following:

(1) The identity of the purchaser.

(2) A description of the terms of the transfer or sale, including the sales price.

(3) A plan for ensuring performance of the existing continuing care contract obligations.

(d) The provider shall give written notice to all continuing care contract residents and depositors 120 calendar days prior to the sale or transfer. The notice shall do all of the following:

(1) Describe the parties.

(2) Describe the proposed sale or transfer.

(3) Describe the arrangements for fulfilling continuing care contract obligations.

(4) Describe options available to any depositor or resident who does not wish to have his or her contract assumed by a new provider.

(5) Include an acknowledgment of receipt of the notice to be signed by the resident.

(e) Unless a new provider assumes all of the continuing care obligations of the selling provider at the close of the sale or transfer,

the selling provider shall set up a trust fund or secure a performance bond to ensure the fulfillment of all its continuing care contract obligations.

(f) The purchaser shall make applications for, and obtain, the appropriate licenses and a certificate of authority before executing any continuing care contracts or assuming the selling provider's continuing care contract obligations.

SEC. 56. Section 1789.6 of the Health and Safety Code is amended to read:

1789.6. A provider shall record with the county recorder a ''Notice of Statutory Limitation on Transfer'' for each community as required by subdivision (aa) of Section 1779.4 and Section 1786.

SEC. 57. Section 1789.8 of the Health and Safety Code is amended to read:

1789.8. Each provider shall obtain and maintain in effect insurance or a fidelity bond for each agent or employee, who, in the course of his or her agency or employment, has access to any substantial amount of funds. This requirement is separate from the bonding requirements of residential care facility for the elderly regulations.

SEC. 57.1. Section 1792 of the Health and Safety Code is repealed.

SEC. 57.15. Section 1792 is added to the Health and Safety Code, to read:

1792. (a) A provider shall maintain at all times qualifying assets as a liquid reserve in an amount that equals or exceeds the sum of the following:

(1) The amount the provider is required to hold as a debt service reserve under Section 1792.3.

(2) The amount the provider must hold as an operating expense reserve under Section 1792.4.

(b) The liquid reserve requirement described in this section is satisfied when a provider holds qualifying assets in the amount required. Except as may be required under subdivision (d), a provider is not required to set aside, deposit into an escrow, or otherwise restrict the assets it holds as its liquid reserve.

(c) A provider shall not allow the amount it holds as its liquid reserve to fall below the amount required by this section. In the event the amount of a provider's liquid reserve is insufficient, the provider shall prudently eliminate the deficiency by increasing its assets qualifying under Section 1792.2.

(d) The department may increase the amount a provider is required to hold as its liquid reserve or require that a provider immediately place its liquid reserve into an escrow account meeting the requirements of Section 1781 if the department has reason to believe the provider is any of the following:

(1) Insolvent.

(2) In imminent danger of becoming insolvent.

(3) In a financially unsound or unsafe condition.

(4) In a condition such that it may otherwise be unable to fully perform its obligations pursuant to continuing care contracts.

SEC. 57.2. Section 1792.1 is added to the Health and Safety Code, to read:

1792.1. (a) For providers that have voluntarily and permanently discontinued entering into continuing care contracts, the department may allow a reduced liquid reserve amount if the department finds that the reduction is consistent with the financial protections imposed by this article. The reduced liquid reserve amount shall be based upon the percentage of residents at the continuing care retirement community who have continuing care contracts.

(b) For providers holding a certificate of authority as of January 1, 2001, the liquid reserve requirement described in Section 1792 shall be phased in over the 24-month period following January 1, 2001. A provider holding a certificate of authority shall comply with the liquid reserve requirements if all of the following apply:

(1) During the first 12 months following January 1, 2001, the provider holds as its liquid reserve, qualifying assets that equal or exceed 25 percent of the provider's debt reserve obligation; plus qualifying assets that equal or exceed 25 percent of the provider's operating expense reserve obligation.

(2) During the 13th through 24th months following January 1, 2001, the provider holds as its liquid reserve, qualifying assets that equal or exceed 50 percent of the provider's debt reserve obligation; plus qualifying assets that equal or exceed 50 percent of the provider's operating expense reserve obligation.

(3) After the 24 months following January 1, 2001, the provider holds as its liquid reserve qualifying assets in the amount required by Section 1792.

(c) Providers who are unable to satisfy the debt service reserve or operating expense reserve requirements during the 24-month period described in subdivision (b) may apply to the department for an extension of the time to comply with those reserve requirements. The department shall grant a one-year extension request to a provider upon its showing that an extension is necessary and consistent with protecting the financial soundness of the provider.

SEC. 57.21. Section 1792.2 of the Health and Safety Code is repealed.

SEC. 57.25. Section 1792.2 is added to the Health and Safety Code, to read:

1792.2. (a) A provider shall satisfy its liquid reserve obligation with qualifying assets. Qualifying assets are:

(1) Cash.

(2) Cash equivalents as defined in paragraph (4) of subdivision (c) of Section 1771.

(3) Investment securities, as defined in paragraph (2) of subdivision (i) of Section 1771.

(4) Equity securities, including mutual funds, as defined in paragraph (7) of subdivision (e) of Section 1771.

(5) Lines of credit and letters of credit that meet the requirements of this paragraph. The line of credit or letter of credit shall be issued by a state or federally chartered financial institution approved by the department or whose long-term debt is rated in the top three long-term debt rating categories by either Moody's Investors Service, Standard and Poor's Corporation, or a recognized securities rating agency acceptable to the department. The line of credit or letter of credit shall obligate the financial institution to furnish credit to the provider.

(A) The terms of the line of credit or letter of credit shall at a minimum provide both of the following:

(i) The department's approval shall be obtained by the provider and communicated in writing to the financial institution before any modification.

(ii) The financial institution shall fund the line of credit or letter of credit and pay the proceeds to the provider no later than four business days following written instructions from the department that, in the sole judgment of the department, funding of the provider's minimum liquid reserve is required.

(B) The provider shall provide written notice to the department at least 14 days before the expiration of the line of credit or letter of credit if the term has not been extended or renewed by that time. The notice shall describe the qualifying assets the provider will use to satisfy the liquid reserve requirement when the line of credit or letter of credit expires.

(C) A provider may satisfy all or a portion of its liquid reserve requirement with the available and unused portion of a qualifying line of credit or letter of credit.

(6) For purposes of satisfying all or a portion of a provider's debt service reserve requirement described in Section 1792.3, restricted assets that are segregated or held in a separate account or escrow as a debt service reserve under the terms of the provider's long-term debt instruments are qualifying assets, subject to all of the following conditions:

(A) The assets are restricted by the debt instrument so that they may be used only to pay principal, interest, and credit enhancement premiums.

(B) The provider furnishes to the department a copy of the agreement under which the restricted assets are held and certifies that it is a correct and complete copy. The provider, escrow holder, or other entity holding the assets must agree to provide to the department any information the department may request concerning the debt service reserve it holds.

(C) The market value, or guaranteed value, if applicable, of the restricted assets, up to the amount the provider must hold as a debt reserve under Section 1792.3, will be included as part of the provider's liquid reserve.

(D) The restricted assets described in this paragraph will not reduce or count towards the amount the provider must hold in its liquid reserve for operating expenses.

(7) For purposes of satisfying all or a portion of a provider's operating expense reserve requirement described in Section 1792.4, restricted assets that are segregated or held in a separate account or escrow as a reserve for operating expenses, are qualifying assets subject to all of the following conditions:

(A) The governing instrument restricts the assets so that they may be used only to pay operating costs when operating funds are insufficient.

(B) The provider furnishes to the department a copy of the agreement under which the assets are held, certified by the provider to be a correct and complete copy. The provider, escrow holder, or other entity holding the assets shall agree to provide to the department any information the department may request concerning the account.

(C) The market value, or the guaranteed value, if applicable, of the restricted assets, up to the amount the provider is required to hold as an operating expense reserve under Section 1792.4, will be included as part of the provider's liquid reserve.

(D) The restricted assets described in this paragraph shall not reduce or count towards the amount the provider is required to hold in its liquid reserve for long-term debt.

(b) Except as otherwise provided in this subdivision, the assets held by the provider as its liquid reserve may not be subject to any liens, charges, judgments, garnishments, or creditors' claims and may not be hypothecated, pledged as collateral, or otherwise encumbered in any manner. A provider may encumber assets held in its liquid reserve as part of a general security pledge of assets or similar collateralization that is part of the provider's long-term capital debt covenants and is included in the provider's long-term debt indenture or similar instrument.

SEC. 57.3. Section 1792.3 is added to the Health and Safety Code, to read:

1792.3. (a) Each provider shall include in its liquid reserve a reserve for its long-term debt obligations in an amount equal to the sum of all of the following:

(1) All regular principal and interest payments, as well as credit enhancement premiums, paid by the provider during the immediately preceding fiscal year on account of any fully amortizing long-term debt owed by the provider. If a provider has incurred new long-term debt during the immediately preceding fiscal year, the

amount required by this paragraph for that debt is 12 times the provider's most recent monthly payment on the debt.

(2) Facility rental or leasehold payments, and any related payments such as lease insurance, paid by the provider during the immediately preceding fiscal year.

(3) All payments paid by the provider during the immediately preceding fiscal year on account of any debt that provides for a balloon payment. If the balloon payment debt was incurred within the immediately preceding fiscal year, the amount required by this paragraph for that debt is 12 times the provider's most recent monthly payment on the debt made during the fiscal year.

(b) If any balloon payment debt matures within the next 24 months, the provider shall submit with its annual report a plan for refinancing the debt or repaying the debt with existing assets.

(c) When principal and interest payments on long-term debt are paid to a trust whose beneficial interests are held by the residents, the department may waive all or any portion of the debt service reserve required by this section. The department shall not waive any debt service reserve requirement unless the department finds that the waiver is consistent with the financial protections imposed by this chapter.

SEC. 57.31. Section 1792.4 is added to the Health and Safety Code, to read:

1792.4. (a) Each provider shall include in its liquid reserve a reserve for its operating expenses in an amount that equals or exceeds 45 days' net operating expenses. For purposes of this section:

(1) Forty-five days net operating expenses shall be calculated by dividing the provider's operating expenses during the immediately preceding fiscal year by 365, and multiplying that quotient by 45.

(2) ''Net operating expenses'' includes all expenses except the following:

(A) The interest and credit enhancement expenses factored into the provider's calculation of its long-term debt reserve obligation described in Section 1792.3.

(B) Depreciation or amortization expenses.

(C) An amount equal to the reimbursement paid to the provider during the past 12 months for services to residents other than residents holding continuing care contracts.

(D) Extraordinary expenses that the department determines may be excluded by the provider. A provider shall apply in writing for a determination by the department and shall provide supporting documentation prepared in accordance with generally accepted accounting principles.

(b) A provider that has been in operation for less than 12 months shall calculate its net operating expenses by using its actual expenses for the months it has operated and, for the remaining months, the

projected net operating expense amounts it submitted to the department as part of its application for a certificate of authority.

SEC. 57.35. Section 1792.5 is added to the Health and Safety Code, to read:

1792.5. (a) The provider shall compute its liquid reserve requirement as of the end of the provider's most recent fiscal yearend based on its audited financial statements for that period and, at the time it files its annual report, shall file a form acceptable to the department certifying all of the following:

(1) The amount the provider is required to hold as a liquid reserve, including the amounts required for the debt service reserve and the operating expense reserve.

(2) The qualifying assets, and their respective values, the provider has designated for its debt service reserve and for its operating expense reserve.

(3) The amount of any deficiency or surplus for the provider's debt service reserve and the provider's operating expense reserve.

(b) The provider shall also complete the same form and file it with the department within 45 days following the conclusion of each quarter during the provider's fiscal year. For each quarterly report, the amount the provider is required to designate for its debt reserve and operating expense reserve shall be based on the provider's audited financial statements for its most recently completed fiscal year.

(c) For the purpose of calculating the amount held by the provider to satisfy its liquid reserve requirement, all qualifying assets used to satisfy the liquid reserve requirements shall be valued at their fair market value as of the end of the provider's most recent quarter. Restricted assets that have guaranteed values and are designated as qualifying assets under paragraph (6) or (7) of subdivision (a) of Section 1792.2 may be valued at their guaranteed values.

SEC. 57.36. Section 1792.6 is added to the Health and Safety Code, to read:

1792.6. (a) Any provider offering a refundable contract, or other entity assuming responsibility for refundable contracts, shall maintain a refund reserve in trust for the residents. The amount of the refund reserve shall be revised annually by the provider and the provider shall submit its calculation of the refund reserve amount to the department in conjunction with the annual report required by Section 1790. This reserve shall accumulate interest and earnings and shall be invested in any of the following:

(1) Qualifying assets as defined in Section 1792.2.

(2) Real estate, subject to all of the following conditions:

(A) To the extent approved by the department, the trust account may invest up to 70 percent of the refund reserves in real estate that is both used to provide care and housing for the holders of the

refundable continuing care contracts and is located on the same campus where these continuing care contractholders reside.

(B) Investments in real estate shall be limited to 50 percent of the providers' net equity in the real estate. The net equity shall be the book value, assessed value, or current appraised value within 12 months prior to the end of the fiscal year, less any depreciation, and encumbrances, all according to audited financial statements acceptable to the department.

(b) Each refund reserve trust shall be established at an institution qualified to be an escrow agent. The escrow agreement between the provider and the institution shall be in writing and include the terms and conditions described in this section. The escrow agreement shall be submitted to and approved by the department before it becomes effective.

(c) The amount to be held in the reserve shall be the total of the amounts calculated with respect to each individual resident holding a refundable contract as follows:

(1) Determine the age in years and the portion of the entry fee for the resident refundable for the seventh year of residency and thereafter.

(2) Determine life expectancy of that individual based on all of the following rules:

(A) The following life expectancy table shall be used in connection with all continuing care contracts:

Age	Females	Males	Age	Females	Males
55	26.323	23.635	83	7.952	6.269
56	25.526	22.863	84	7.438	5.854
57	24.740	22.101	85	6.956	5.475
58	23.964	21.350	86	6.494	5.124
59	23.199	20.609	87	6.054	4.806
60	22.446	19.880	88	5.613	4.513
61	21.703	19.163	89	5.200	4.236
62	20.972	18.457	90	4.838	3.957
63	20.253	17.764	91	4.501	3.670
64	19.545	17.083	92	4.175	3.388
65	18.849	16.414	93	3.862	3.129
66	18.165	15.759	94	3.579	2.903
67	17.493	15.116	95	3.329	2.705
68	16.832	14.486	96	3.109	2.533
69	16.182	13.869	97	2.914	2.384
70	15.553	13.268	98	2.741	2.254
71	14.965	12.676	99	2.584	2.137

72	14.367	12.073	100	2.433	2.026
73	13.761	11.445	101	2.289	1.919
74	13.189	10.830	102	2.152	1.818
75	12.607	10.243	103	2.022	1.723
76	12.011	9.673	104	1.899	1.637
77	11.394	9.139	105	1.784	1.563
78	10.779	8.641	106	1.679	1.510
79	10.184	8.159	107	1.588	1.500
80	9.620	7.672	108	1.522	1.500
81	9.060	7.188	109	1.500	1.500
82	8.501	6.719	110	1.500	1.500

(B) If there is a couple, the life expectancy for the person with the longer life expectancy shall be used.

(C) The life expectancy table set forth in this paragraph shall be used until expressly provided to the contrary through the amendment of this section.

(D) For residents over 110 years of age, 1.500 years shall be used in computing life expectancy.

(E) If a continuing care retirement community has contracted with a resident under 55 years of age, the continuing care retirement community shall provide the department with the methodology used to determine that resident's life expectancy.

(3) For that resident, use an interest rate of 6 percent or lower to determine from compound interest tables the factor that, when multiplied by one dollar ($1), represents the amount, at the time the computation is made, that will grow at the assumed compound interest rate to one dollar ($1) at the end of the period of the life expectancy of the resident.

(4) Multiply the refundable portion of the resident's entry fee amount by the factor obtained in paragraph (3) to determine the amount of reserve required to be maintained.

(5) The sum of these amounts with respect to each resident shall constitute the reserve for refundable contracts.

(6) The reserve for refundable contracts shall be revised annually as provided for in subdivision (a), using the interest rate, refund obligation amount, and individual life expectancies current at that time.

(d) Withdrawals may be made from the trust to pay refunds when due under the terms of the refundable entrance fee contracts and when the balance in the trust exceeds the required refund reserve amount determined in accordance with subdivision (c).

(e) Deposits shall be made to the trust with respect to new residents when the entrance fee is received and in the amount

determined with respect to that resident in accordance with subdivision (c).

(f) Additional deposits shall be made to the trust fund within 30 days of any annual reporting date on which the trust fund balance falls below the required reserve in accordance with subdivision (c) and the deposits shall be in an amount sufficient to bring the trust balance into compliance with this section.

(g) Providers who have used a method previously allowed by statute to satisfy their refund reserve requirement may continue to use that method.

SEC. 57.4. Article 6.5 (commencing with Section 1792.11) is added to Chapter 10 of Division 2 of the Health and Safety Code, to read:

Article 6.5. Actuarial Study

1792.11. The Legislature finds and declares all of the following:

(a) In continuing care contracts, providers offer a wide variety of living accommodations and care programs for an indefinite or extended number of years in exchange for substantial payments by residents over the term of the contract.

(b) The annual reporting and reserve requirements for continuing care providers should address a provider's long-term solvency. The past statutes establishing reserve requirements did not satisfactorily address this issue.

(c) One method for comprehensively assessing a continuing care provider's long-term solvency, that may have significant potential benefits for residents, providers, and the department, is an actuarial study performed in compliance with Actuarial Standards of Practice Number 3 as adopted by the Actuarial Standards Board.

(d) The continuing care statutes should, during a test period sufficient to apply the actuarial study requirement to all appropriate providers, require those providers to obtain and file with the department an actuarial study.

(e) Fundamental to the effectiveness of actuarial studies are the assumptions used to project costs and revenues, as well as the breadth of the data base from which many of the assumptions are derived. For this and other reasons, neither the issues that will arise during the department's management of the actuarial study requirement nor the immediate impact of the actuarial study requirement on the continuing care industry can be fully anticipated.

(f) In the context of the foregoing, it is in the public's interest that:

(1) The statutes applicable to continuing care retirement communities require all providers, with certain exceptions, to conduct a one-time comprehensive assessment of their long-term solvency and to report that assessment to the department.

(2) The statutes applicable to continuing care retirement communities implement a four-year trial program that requires specified continuing care providers, and applicants for a certificate of authority, to conduct an actuarial study.

(3) The stability and longevity of the continuing care industry not be threatened by the four-year test program or dissemination by the department of any provider's actuarial study within four years of the filing date for the actuarial study.

(4) During a four-year trial period, the department, as well as provider and resident representatives, assess the effectiveness of using actuarial studies to analyze the long-term financial viability of the providers in California.

1792.12. (a) The department shall implement in conformance with this article a four-year trial program for examining, and reporting on, the long-term solvency of specified continuing care providers.

(b) Under the program, the department shall require providers to obtain an actuarial study conducted in compliance with the Actuarial Standards of Practice Number 3 and then to file their actuarial study with the department.

(c) It is the intent of the Legislature that the four-year trial program shall do both of the following:

(1) Allow the department to consider the effectiveness and role of actuarial studies in the department's discharge of its obligation to assess each provider's financial soundness.

(2) Allow providers, the department, and resident representatives to evaluate the actuarial study requirement, including the reliability of actuarial studies and their value if statutorily included in the regimen of continuing care providers' financial reporting and disclosure obligations.

(d) The department shall, during the four-year period following the filing due date for a provider's actuarial study required under this article, maintain the confidentiality of the actuarial study.

(e) The department's responsibility to manage the four-year trial program and review the providers' actuarial studies under this article represents a significant burden on its resources dedicated to its oversight of the continuing care industry. The department is specifically authorized to use third-party professional consultants as necessary to properly discharge its responsibilities under this article and to also allocate resources from the Continuing Care Provider Fee Fund as necessary to retain within the department the level of expertise required by the program.

(f) During the four-year trial program, the five-hundred-thousand-dollar ($500,000) ceiling on the projected annual balance for the Continuing Care Provider Fee Fund specified in Section 1778 shall be increased to seven hundred fifty thousand dollars ($750,000).

1792.13. (a) During the four-year trial period, the department shall continually assess the effectiveness of using actuarial studies to analyze the long-term financial position of the providers in California.

(b) On January 1, 2003, the department shall form a nine-member panel after consultation with the prominent residents' associations, the prominent providers' associations, and the Continuing Care Advisory Committee. The department shall appoint to the panel three resident representatives, three provider representatives, and three representatives of the department. The panel shall determine the value of the actuarial study requirement in terms of all of the following:

(1) Its effectiveness as a method for assessing a provider's long-term solvency.

(2) Its usefulness to the department in the discharge of its statutory oversight responsibilities regarding providers' financial soundness.

(3) Its usefulness to providers as a management tool.

(4) Its effectiveness as a method for disclosing financial information regarding providers to residents and potential residents of continuing care facilities.

(c) The expenses incurred by the panel's members shall be charged to the Continuing Care Provider Fee Fund in the same manner and to the same extent as the expenses incurred by the members of the Continuing Care Advisory Committee are charged to the Continuing Care Provider Fee Fund under this chapter.

(d) The panel shall issue a report to the department before February 13, 2004. The report shall include the panel's findings and any statutory changes it proposes to implement its findings. The report shall specifically address whether the actuarial study requirement should continue as law, and if so, it shall also reexamine how best to classify providers for purposes of the actuarial study requirement and recommend the appropriate interval between the actuarial studies required for each type of provider. If the panel advises against continuing the actuarial study requirement, the panel:

(1) May recommend an alternative process, or ratify existing processes for evaluating and reporting a provider's long-term solvency.

(2) Shall reexamine the adequacy of the reserve requirements stated in Article 6 (commencing with Section 1789) and make any recommendations it deems appropriate.

(3) Shall reexamine the disclosure obligations of providers in regard to their long-term solvency and make any recommendations it deems appropriate.

(e) The department shall submit recommendations to the Legislature as necessary to implement the recommendations of the

panel through the enactment of legislation that would be effective on or before January 1, 2005.

1792.14. (a) For purposes of this article, ‘‘actuarial study’’ means an analysis that addresses the current actuarial financial condition of a provider that is performed by an actuary in accordance with accepted actuarial principles and the standards of practice adopted by the Actuarial Standards Board. An actuarial study shall include all of the following:

(1) An actuarial report.

(2) A statement of actuarial opinion.

(3) An actuarial balance sheet.

(4) A cohort pricing analysis.

(5) A cash-flow projection.

(6) A description of the actuarial methodology, formulae, and assumptions.

(b) ‘‘Actuary’’ means a member in good standing of the American Academy of Actuaries who is qualified to sign a statement of actuarial opinion.

1792.15. (a) An actuarial study, prepared or reviewed by an actuary, shall be submitted to the department by every applicant proposing a new continuing care retirement community except those applicants that, as of January 1, 2001, have fully satisfied the requirements of Section 1780 for issuance of a permit to accept deposits related to the proposed project. The actuarial study shall demonstrate that the proposed continuing care retirement community’s financial position is in satisfactory actuarial balance and shall include all of the following:

(1) An actuarial balance sheet that demonstrates that, for a hypothetical cohort of new residents at the proposed continuing care retirement community, the sum of the entrance fees to be paid at occupancy plus the actuarial present value at occupancy of those residents’ periodic fees equals the actuarial present value at occupancy of the costs of performing all obligations to those residents under their continuing care contracts, plus appropriate provision for surplus.

(2) Supporting detailed documentation for the actuarial balance sheet, including all of the following:

(A) A projection of future population flows, for the first 20 years, using appropriate mortality, morbidity, withdrawal, and other demographic assumptions.

(B) A projection of future health care needs and corresponding costs by level of care, for the first 20 years, using appropriate inflation factors, mortality, morbidity, withdrawal, and other demographic assumptions.

(C) A description of the actuarial data, assumptions, and methods used to create the projections in the actuarial report.

(3) A pricing analysis that demonstrates that, for a typical cohort of replacement residents at the continuing care retirement community, the sum of the entrance fees to be paid at occupancy plus the actuarial present value at occupancy of periodic fees paid by the residents equals the actuarial present value at occupancy of the costs of performing all obligations to the residents under their continuing care contracts, with appropriate provision for surplus.

(4) Cash-flow statements that project positive cash balances for a 20-year period.

(5) The opinion of the actuary that the data and assumptions used are reasonable and appropriate, the methods employed are consistent with sound actuarial principles and practices, and provision has been made for all actuarial liabilities and related statement items.

1792.16. (a) Each provider shall submit an actuarial study to the department during the years specified in Section 1792.18.

(b) All actuarial studies shall be prepared or reviewed by an actuary and shall include all of the following:

(1) An actuarial balance sheet that demonstrates whether the resources available for current residents, including the actuarial present value of periodic fees to be paid by the residents, is greater than or equal to the actuarial present value of the costs of performing all remaining obligations to those residents under their continuing care contracts, with appropriate provision for surplus.

(2) Supporting detailed documentation for the actuarial balance sheet, including all of the following:

(A) A projection of future population flows, for the next 20 years, using appropriate mortality, morbidity, withdrawal, and other demographic assumptions.

(B) A projection of future health care needs and corresponding costs, for the next 20 years, using appropriate inflation factors, mortality, morbidity, withdrawal, and other demographic assumptions.

(C) A description of the actuarial data, assumptions, and methods used to create the projections in the actuarial study.

(3) A pricing analysis that demonstrates whether, for a typical cohort of replacement residents at the continuing care retirement community, the sum of the entrance fees to be paid at occupancy plus the actuarial present value at occupancy of periodic fees paid by the residents equals the actuarial present value at occupancy of the costs of performing all remaining obligations to the residents under their continuing care contracts, with appropriate provision for surplus.

(4) Cash-flow statements that project cash balances with respect to current and future residents for a period of at least 20 years.

(5) The opinion of the actuary that the data and assumptions used are appropriate, the methods employed are consistent with sound

actuarial principles and practices, and whether provision has been made for all actuarial liabilities and related statement items.

1792.17. (a) For purposes of this section, the term ‘‘health care guarantee’’ means the degree to which the fees charged by a provider in a continuing care contract for health care, including assisted living services and skilled nursing care, are less than the fees charged by the provider on a per diem basis to noncontinuing care residents. The three types of health care guarantees are extensive, limited, and nominal and are described as follows:

(1) An extensive health care guarantee exists in all life care contracts and prepaid contracts as well as all other continuing care contracts where a resident either:

(A) Pays the same or nearly the same monthly fee for health care, including temporary or permanent assisted living services or skilled nursing care, as the resident was charged while residing in an independent living unit.

(B) Pays a rate for health care, including temporary or permanent assisted living or skilled nursing care, that, regardless of the duration of his or her health care needs, is 80 percent or less of the per diem rate charged to noncontinuing care contract residents.

(2) A limited health care guarantee exists in all continuing care contracts where the health care guarantee is not extensive or nominal.

(3) A nominal health care guarantee exists in all continuing care contracts where the resident is charged less than the per diem rate charged to noncontinuing care residents for health care for five or fewer days in any 12-month period and otherwise pays on a per diem basis for all levels of health care.

(b) The department shall classify each provider as a Type I Provider, a Type II Provider, or a Type III Provider based on the following:

(1) A Type I Provider is a provider that has entered into a continuing care contract that includes an extensive health care guarantee.

(2) A Type II Provider is a provider to which both of the following apply:

(A) Has entered into a continuing care contract that includes a limited health care guarantee.

(B) Has not entered into any continuing care contract that includes an extensive health care guarantee.

(3) A Type III Provider is a provider that satisfies either of the following:

(A) It has only entered into continuing care contracts that include nominal health care guarantees.

(B) It does not charge entrance fees or monthly service fees, such as those providers who accept an assignment of assets and fund the costs of providing care with charitable contributions.

1792.18. (a) A provider shall file its actuarial study within 45 days after the due date for its annual report. Each provider that operates more than one continuing care retirement community shall prepare one actuarial study encompassing all its communities and shall be assigned a single date for filing its actuarial study. All providers shall file actuarial studies with the department during the years specified as follows:

(1) Each provider classified as a Type I Provider shall file an initial actuarial study following its annual report filed during the 2001 calendar year. A Type I Provider that has completed an actuarial study satisfying the requirements of this article during the 2000 calendar year may file that actuarial study with the department in order to satisfy the provider's obligation under this section.

(2) Each provider classified as a Type II Provider shall file an initial actuarial study according to the following schedule:

(A) Six of the providers holding certificates of authority on January 1, 2001, or a lesser number, at the department's discretion, shall file their actuarial studies following their annual report filed during the 2001 calendar year.

(B) One-half of the remaining number of providers holding certificates of authority on January 1, 2001, shall file their actuarial studies following their annual reports filed during the 2002 calendar year.

(C) The remaining providers holding certificates of authority on January 1, 2001, shall file their actuarial studies following their annual reports filed during the 2003 calendar year.

(3) A provider classified as a Type III Provider shall not be obligated by this article to file an actuarial study.

(b) As soon as practicable following January 1, 2001, the Continuing Care Advisory Committee shall select randomly those Type II Providers that will be required to file their actuarial studies following their annual reports filed during the 2001, 2002, and 2003 calendar years. A Type II Provider that has completed an actuarial study satisfying the requirements of this article during the 2000 calendar year may request that the department both designate the provider as one of the providers that is required to file an actuarial study in the 2001 calendar year and that the provider's 2000 calendar year actuarial study be accepted by the department in satisfaction of the provider's obligation to file an actuarial study in the 2001 calendar year. A provider shall submit to the department a copy of its 2000 calendar year actuarial study with its request.

(c) Applicants that have applications pending as of January 1, 2001, shall file an actuarial study as follows:

(1) Applicants that submitted an actuarial study with their application shall file their initial actuarial study as a provider during the year they file their first annual report after the earliest of the following occurs:

(A) The new continuing care retirement community reaches 85-percent occupancy.

(B) Thirty months following the issuance of a preliminary certificate of authority for the new continuing care retirement community.

(2) All other applicants shall file their initial actuarial study during the year they file their first annual report.

(d) A provider shall pay a one-thousand-dollar ($1,000) late fee if it fails to file its actuarial study on or before the date it is due. A provider shall pay an additional late fee of thirty-three dollars ($33) per day for each day after the first 30 days that the actuarial study is late. All late fees due shall accompany the actuarial study when it is filed or late fees shall continue to accrue until paid. The late fees described in this subdivision are separate from, and accrue independently of, any other late fees that may apply if a provider fails to file its annual report when due. The department may, at its discretion, waive this late fee upon a showing of good cause by the provider.

1792.19. (a) Each actuarial study required of a provider by Section 1792.16 shall demonstrate that the provider's financial condition is in satisfactory actuarial balance, including an appropriate surplus, such that the provider has the financial resources to meet all its actuarial liabilities. A provider's financial condition is in satisfactory actuarial balance if its actuarial study includes all of the following:

(1) An actuarial balance sheet that demonstrates the resources available for current residents at the continuing care retirement community, including the actuarial present value of periodic fees to be paid by the residents, at least equals the actuarial present value of the costs of performing all remaining obligations to those residents under their continuing care contracts, with appropriate provision for surplus.

(2) A pricing analysis that demonstrates, for a typical cohort of replacement residents at the continuing care retirement community, the sum of the entrance fees to be paid at occupancy plus the actuarial present value at occupancy of periodic fees paid by the residents equals the actuarial present value at occupancy of the costs of performing all remaining obligations to the residents under their continuing care contracts, with appropriate provision for surplus.

(3) Cash-flow statements that project positive cash balances with respect to current and future residents for a period of at least 20 years.

(4) The opinion of the actuary that provision has been made for all actuarial liabilities and related statement items.

(b) In the event that an actuarial study shows insufficient financial resources to meet all its actuarial liabilities or an actuarial balance sheet deficit, the actuarial report shall clearly state the implications of the provider's financial condition. The report shall specifically

describe management's plans for improving its financial position to achieve an actuarial balance including an appropriate surplus. In addition, the provider shall submit with its actuarial study a detailed narrative addressing its actuarial deficiency and describing its plan to achieve actuarial balance.

1792.20. (a) Each provider that has submitted an actuarial study to the department shall, after the close of each fiscal year, review and compare its actual results from operations during the closed year to the assumptions made in its actuarial study for that year in a form prescribed by the department.

(b) Providers are not required to file the statement described in subdivision (a) in any year that they file an actuarial report.

1792.21. Any unpaid fines accruing or assessed under the provisions of this article as of January 1, 2005, when this article is repealed pursuant to Section 1792.22 shall remain payable and continue to accrue in the same manner as provided in this article.

1792.22. This article shall remain in effect only until January 1, 2005, and as of that date is repealed.

SEC. 58. Section 1793.5 of the Health and Safety Code is amended to read:

1793.5. (a) An entity that accepts deposits and proposes to promise to provide care without having a current and valid permit to accept deposits is guilty of a misdemeanor.

(b) An entity that accepts deposits and fails to place any deposit received into an escrow account as required by this chapter is guilty of a misdemeanor.

(c) An entity that executes a continuing care contract without holding a current and valid provisional certificate of authority or certificate of authority is guilty of a misdemeanor.

(d) An entity that abandons a continuing care retirement community or its obligations under a continuing care contract is guilty of a misdemeanor. An entity that violates this section shall be liable to the injured resident for treble the amount of damages assessed in any civil action brought by or on behalf of the resident in any court having proper jurisdiction. The court may, in its discretion, award all costs and attorney fees to the injured resident, if that resident prevails in the action.

(e) Each violation of subdivision (a), (b), (c), or (d) is subject to a fine not to exceed ten thousand dollars ($10,000), or by imprisonment in the county jail for a period not to exceed one year, or by both.

(f) An entity that issues, delivers, or publishes, or as manager or officer or in any other administrative capacity, assists in the issuance, delivery, or publication of any printed matter, oral representation, or advertising material which does not comply with the requirements of this chapter is guilty of a misdemeanor.

(g) A violation of subdivision (f) by an entity will constitute cause for the suspension of all and any licenses, permits, provisional certificates of authority, and certificates of authority issued to that entity by any agency of the state.

(h) A violation under this section is an act of unfair competition as defined in Section 17200 of the Business and Professions Code.

SEC. 59. Section 1793.6 of the Health and Safety Code is amended to read:

1793.6. (a) The department may issue citations pursuant to this section containing orders of abatement and assessing civil penalties against any entity that violates Section 1771.2 or 1793.5.

(b) If upon inspection or investigation, the department has probable cause to believe that an entity is violating Section 1771.2 or 1793.5, the department may issue a citation to that entity. Each citation shall be in writing and shall describe with particularity the basis of the citation. Each citation shall contain an order of abatement. In addition to the administrative fines imposed pursuant to Section 1793.27, an entity that violates the abatement order shall be liable for a civil penalty in the amount of two hundred dollars ($200) per day for violation of the abatement order.

(c) The civil penalty authorized in subdivision (b) shall be imposed if a continuing care retirement community is operated without a provisional certificate of authority or certificate of authority and the operator refuses to seek a certificate of authority or the operator seeks a certificate of authority and the application is denied and the operator continues to operate the continuing care retirement community without a provisional certificate of authority or certificate of authority, unless other remedies available to the department, including prosecution, are deemed more appropriate by the department.

(d) Service of a citation issued under this section may be made by certified mail at the last known business address or residence address of the entity cited.

(e) Within 15 days after service of a citation under this section, an entity may appeal in writing to the department with respect to the violations alleged, the scope of the order of abatement, or the amount of civil penalty assessed.

(f) If the entity cited fails without good cause to appeal in writing to the department within 15 business days after service of the citation, the citation shall become a final order of the department. The department may extend the 15-day period for good cause, to a maximum of 15 additional days.

(g) If the entity cited under this section makes a timely appeal of the citation, the department shall provide an opportunity for a hearing. The department shall thereafter issue a decision, based on findings of fact, affirming, modifying, or vacating the citation or directing other appropriate relief. The proceedings under this

section shall be conducted in accordance with the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the department shall have all the powers granted therein.

(h) After exhaustion of the review procedures specified in this section, the department may apply to the appropriate superior court for a judgment in the amount of the civil penalty and an order compelling the cited entity to comply with the order of abatement. The application, which shall include a certified copy of the final order of the department shall be served upon the cited entity who shall have five business days to file that entity's response in writing in the superior court. This period may be extended for good cause. Failure on the part of the cited entity to respond shall constitute grounds for entry of a default judgment against that entity. In the event a response is timely filed in superior court, the action shall have priority for trial over all other civil matters.

(i) Notwithstanding any other provision of law, the department may waive part or all of the civil penalty if the entity against whom the civil penalty is assessed satisfactorily completes all the requirements for, and is issued, a provisional certificate of authority or certificate of authority.

(j) Civil penalties recovered pursuant to this section shall be deposited into the Continuing Care Provider Fee Fund.

SEC. 60. Section 1793.7 of the Health and Safety Code is amended to read:

1793.7. A permit to accept deposits, a provisional certificate of authority, or a certificate of authority shall be forfeited by operation of law when any one of the following occurs:

(a) The applicant terminates marketing for the proposed continuing care retirement community.

(b) The applicant or provider surrenders to the department its residential care facility for the elderly license, the permit to accept deposits, provisional certificate of authority, or certificate of authority for a continuing care retirement community.

(c) The applicant or provider sells or otherwise transfers all or part of the continuing care retirement community.

(d) A change occurs in the majority ownership of the continuing care retirement community or the certificate of authority holder.

(e) The applicant or provider merges with another entity.

(f) The applicant or entity makes a material change in a pending application which requires a new application pursuant to subdivision (c) of Section 1779.8.

(g) The applicant or provider moves the continuing care retirement community from one location to another without the department's prior approval.

(h) The applicant or provider abandons the continuing care retirement community or its obligations under the continuing care contracts.

(i) The applicant or provider is evicted from the continuing care retirement community premises.

SEC. 61. Section 1793.8 of the Health and Safety Code is amended to read:

1793.8. A Certificate of Authority shall be automatically inactivated when a provider voluntarily ceases to enter into continuing care contracts with new residents. The provider shall notify the department of its intention to cease entering into continuing care contracts and shall continue to comply with all provisions of this chapter until all continuing care contract obligations have been fulfilled.

SEC. 62. Section 1793.9 of the Health and Safety Code is amended to read:

1793.9. (a) In the event of liquidation, all claims made against a provider based on the provider's continuing care contract obligations shall be preferred claims against all assets owned by the provider. However, these preferred claims shall be subject to any perfected claims secured by the provider's assets.

(b) If the provider is liquidated, residents who have executed a refundable continuing care contract shall have a preferred claim to liquid assets held in the refund reserve pursuant to Section 1792.6. This preferred claim shall be superior to all other claims from residents without refundable contracts or other creditors. If this fund and any other available assets are not sufficient to fulfill the refund obligations, each resident shall be distributed a proportionate amount of the refund reserve funds determined by dividing the amount of each resident's refund due by the total refunds due and multiplying that percentage by the total funds available.

(c) For purposes of computing the reserve required pursuant to Sections 1792.2 and 1793, the liens required under Section 1793.15 are not required to be deducted from the value of real or personal property.

SEC. 63. Section 1793.11 of the Health and Safety Code is amended to read:

1793.11. (a) Any transfer of money or property, pursuant to a continuing care contract found by the department to be executed in violation of this chapter, is voidable at the option of the resident or transferor for a period of 90 days from the execution of the transfer.

(b) Any deed or other instrument of conveyance shall contain a recital that the transaction is made pursuant to rescission by the resident or transferor within 90 days from the date of first occupancy.

(c) No action may be brought for the reasonable value of any services rendered between the date of transfer and the date the resident disaffirms the continuing care contract.

(d) With respect to real property, the right of disaffirmance or rescission is conclusively presumed to have terminated if a notice of intent to rescind is not recorded with the county recorder of the county in which the real property is located within 90 days from the date of first occupancy of the residential living unit.

(e) A transfer of money or property, real or personal, to anyone pursuant to a continuing care contract that was not approved by the department is voidable at the option of the department or transferor or his or her assigns or agents.

(f) A transaction determined by the department to be in violation of this chapter is voidable at the option of the resident or his or her assignees or agents.

SEC. 64. Section 1793.13 of the Health and Safety Code is amended to read:

1793.13. (a) The department may require a provider to submit a financial plan, if either of the following applies:

(1) A provider fails to file a complete annual report as required by Section 1790.

(2) The department has reason to believe that the provider is insolvent, is in imminent danger of becoming insolvent, is in a financially unsound or unsafe condition, or that its condition is such that it may otherwise be unable to fully perform its obligations pursuant to continuing care contracts.

(b) A provider shall submit its financial plan to the department within 60 days following the date of the department's request. The financial plan shall explain how and when the provider will rectify the problems and deficiencies identified by the department.

(c) The department shall approve or disapprove the plan within 30 days of its receipt.

(d) If the plan is approved, the provider shall immediately implement the plan.

(e) If the plan is disapproved, or if it is determined that the plan is not being fully implemented, the department may, after consultation with and upon consideration of the recommendations of the Continuing Care Advisory Committee, consult with its financial consultants to develop a corrective action plan at the provider's expense, or require the provider to obtain new or additional management capability approved by the department to solve its difficulties. A reasonable period, as determined by the department, shall be allowed for the reorganized management to develop a plan which, subject to the approval of the department and after review by the committee, will reasonably assure that the provider will meet its responsibilities under the law.

SEC. 65. Section 1793.15 of the Health and Safety Code is amended to read:

1793.15. (a) When necessary to secure an applicant's or a provider's performance of its obligations to depositors or residents,

the department may record a notice or notices of lien on behalf of the depositors or residents. From the date of recording, the lien shall attach to all real property owned or acquired by the provider during the pendency of the lien, provided the property is not exempt from the execution of a lien and is located within the county in which the lien is recorded. The lien shall have the force, effect, and priority of a judgment lien.

(b) The department may record a lien on any real property owned by the provider if the provider's annual report indicates the provider has an unfunded statutory or refund requirement. A lien filed pursuant to this section shall have the effect, force, and priority of a judgment lien filed against the property.

(c) The department shall file a release of the lien if the department determines that the lien is no longer necessary to secure the applicant's or provider's performance of its obligations to the depositors or residents.

(d) Within 10 days following the department's denial of a request for a release of the lien, the applicant or provider may file an appeal with the department.

(e) The department's final decision shall be subject to court review pursuant to Section 1094.5 of the Code of Civil Procedure, upon petition of the applicant or provider filed within 30 days of service of the decision.

SEC. 66. Section 1793.17 of the Health and Safety Code is amended to read:

1793.17. (a) When necessary to secure the interests of depositors or residents, the department may require that the applicant or provider reestablish an escrow account, return previously released moneys to escrow, and escrow all future entrance fee payments.

(b) The department may release funds from escrow as it deems appropriate or terminate the escrow requirement when it determines that the escrow is no longer necessary to secure the performance of all obligations of the applicant or provider to depositors or residents.

SEC. 67. Section 1793.19 of the Health and Safety Code is amended to read:

1793.19. The civil, criminal, and administrative remedies available to the department pursuant to this article are not exclusive and may be sought and employed by the department, in any combination to enforce this chapter.

SEC. 68. Section 1793.21 of the Health and Safety Code is amended to read:

1793.21. The department, in its discretion, may condition, suspend, or revoke any permit to accept deposits, provisional certificate of authority, or certificate of authority issued under this chapter if it finds that the applicant or provider has done any of the following:

(a) Violated this chapter or the rules and regulations adopted under this chapter.

(b) Aided, abetted, or permitted the violation of this chapter or the rules and regulations adopted under this chapter.

(c) Had a license suspended or revoked pursuant to the licensing provisions of Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569).

(d) Made a material misstatement, misrepresentation, or fraud in obtaining the permit to accept deposits, provisional certificate of authority, or certificate of authority.

(e) Demonstrated a lack of fitness or trustworthiness.

(f) Engaged in any fraudulent or dishonest practices of management in the conduct of business.

(g) Misappropriated, converted, or withheld moneys.

(h) After request by the department for an examination, access to records, or information, refused to be examined or to produce its accounts, records, and files for examination, or refused to give information with respect to its affairs, or refused to perform any other legal obligations related to an examination.

(i) Manifested an unsound financial condition.

(j) Used methods and practices in the conduct of business so as to render further transactions by the provider or applicant hazardous or injurious to the public.

(k) Failed to maintain at least the minimum statutory reserves required by Section 1792.2.

(*l*) Failed to maintain the reserve fund escrow account for prepaid continuing care contracts required by Section 1792.

(m) Failed to comply with the refund reserve requirements stated in Section 1793.

(n) Failed to comply with the requirements of this chapter for maintaining escrow accounts for funds.

(o) Failed to file the annual report described in Section 1790.

(p) Violated a condition on its permit to accept deposits, provisional certificate of authority, or certificate of authority.

(q) Failed to comply with its approved financial and marketing plan or to secure approval of a modified plan.

(r) Materially changed or deviated from an approved plan of operation without the prior consent of the department.

(s) Failed to fulfill his or her obligations under continuing care contracts.

(t) Made material misrepresentations to depositors, prospective residents, or residents of a continuing care retirement community.

(u) Failed to submit proposed changes to continuing care contracts prior to use, or using a continuing care contract that has not been previously approved by the department.

(v) Failed to diligently submit materials requested by the department or required by the statute.

SEC. 69. Section 1793.23 of the Health and Safety Code is amended to read:

1793.23. (a) The department shall consult with and consider the recommendations of the Continuing Care Advisory Committee prior to conditioning, suspending, or revoking any permit to accept deposits, provisional certificate of authority, or certificate of authority.

(b) The provider shall have a right of appeal to the department. The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the department shall have all of the powers granted therein. A suspension, condition, or revocation shall remain in effect until completion of the proceedings in favor of the provider. In all proceedings conducted in accordance with this section, the standard of proof to be applied shall be by a preponderance of the evidence.

(c) The department may, upon finding of changed circumstances, remove a suspension or condition.

SEC. 70. Section 1793.25 of the Health and Safety Code is amended to read:

1793.25. (a) During the period that the revocation or suspension action is pending against the permit to accept deposits, provisional certificate of authority, or certificate of authority, the provider shall not enter into any new deposit agreements or continuing care contracts.

(b) The suspension or revocation by the department, or voluntary return of the provisional certificate of authority or certificate of authority by the provider, shall not release the provider from obligations assumed at the time the continuing care contracts were executed.

SEC. 71. Section 1793.27 of the Health and Safety Code is amended to read:

1793.27. (a) If the department finds that any entity has violated Section 1793.5 or one or more grounds exist for conditioning, revoking, or suspending a permit to accept deposits, provisional certificate of authority, or a certificate of authority issued under this chapter, the department, in lieu of the condition, revocation, or suspension, may impose an administrative fine upon an applicant or provider in an amount not to exceed one thousand dollars ($1,000) per violation.

(b) The administrative fine shall be deposited in the Continuing Care Provider Fee Fund and shall be disbursed for the specific purposes of offsetting the costs of investigation and litigation and to compensate court-appointed administrators when continuing care retirement community assets are insufficient.

SEC. 72. Section 1793.29 of the Health and Safety Code is amended to read:

1793.29. In the case of any violation or threatened violation of this chapter, the department may institute a proceeding or may request the Attorney General to institute a proceeding to obtain injunctive or other equitable relief in the superior court in and for the county in which the violation has occurred or will occur, or in which the principal place of business of the provider is located. The proceeding under this section shall conform with the requirements of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that no undertaking shall be required of the department in any action commenced under this section, nor shall the department be required to allege facts necessary to show lack of adequate remedy at law, or to show irreparable loss or damage.

SEC. 73. Section 1793.50 of the Health and Safety Code is amended to read:

1793.50. (a) The department, after consultation with the Continuing Care Advisory Committee, may petition the superior court for an order appointing a qualified administrator to operate a continuing care retirement community, and thereby mitigate imminent crisis situations where elderly residents could lose support services or be moved without proper preparation, in any of the following circumstances:

(1) The provider is insolvent or in imminent danger of becoming insolvent.

(2) The provider is in a financially unsound or unsafe condition.

(3) The provider has failed to establish or has substantially depleted the reserves required by this chapter.

(4) The provider has failed to submit a plan, as specified in Section 1793.13, the department has not approved the plan submitted by the provider, the provider has not fully implemented the plan, or the plan has not been successful.

(5) The provider is unable to fully perform its obligations pursuant to continuing care contracts.

(6) The residents are otherwise placed in serious jeopardy.

(b) The administrator may only assume the operation of the continuing care retirement community in order to accomplish one or more of the following: rehabilitate the provider to enable it fully to perform its continuing care contract obligations; implement a plan of reorganization acceptable to the department; facilitate the transition where another provider assumes continuing care contract obligations; or facilitate an orderly liquidation of the provider.

(c) With each petition, the department shall include a request for a temporary restraining order to prevent the provider from disposing of or transferring assets pending the hearing on the petition.

(d) The provider shall be served with a copy of the petition, together with an order to appear and show cause why management and possession of the provider’s continuing care retirement community or assets should not be vested in an administrator.

(e) The order to show cause shall specify a hearing date, which shall be not less than five nor more than 10 days following service of the petition and order to show cause on the provider.

(f) Petitions to appoint an administrator shall have precedence over all matters, except criminal matters, in the court.

(g) At the time of the hearing, the department shall advise the provider and the court of the name of the proposed administrator.

(h) If, at the conclusion of the hearing, including such oral evidence as the court may consider, the court finds that any of the circumstances specified in subdivision (a) exist, the court shall issue an order appointing an administrator to take possession of the property of the provider and to conduct the business thereof, enjoining the provider from interfering with the administrator in the conduct of the rehabilitation, and directing the administrator to take steps toward removal of the causes and conditions which have made rehabilitation necessary, as the court may direct.

(i) The order shall include a provision directing the issuance of a notice of the rehabilitation proceedings to the residents at the continuing care retirement community and to other interested persons as the court may direct.

(j) The court may permit the provider to participate in the continued operation of the continuing care retirement community during the pendency of any appointments ordered pursuant to this section and shall specify in the order the nature and scope of the participation.

(k) The court shall retain jurisdiction throughout the rehabilitation proceeding and may issue further orders as it deems necessary to accomplish the rehabilitation or orderly liquidation of the continuing care retirement community in order to protect the residents of the continuing care retirement community.

SEC. 74. Section 1793.56 of the Health and Safety Code is amended to read:

1793.56. (a) The appointed administrator is entitled to reasonable compensation.

(b) The costs compensating the administrator may be charged against the assets of the provider. When the provider’s assets and assets from the continuing care retirement community are insufficient, the department, in its discretion, may compensate the administrator from the Continuing Care Provider Fee Fund.

(c) Any individual appointed administrator, pursuant to Section 1793.50, shall be held harmless for any negligence in the performance of his or her duties and the provider shall indemnify the administrator for all costs of defending actions brought against him or her in his or her capacity as administrator.

SEC. 75. Section 1793.58 of the Health and Safety Code is amended to read:

1793.58. (a) The department, administrator, or any interested person, upon due notice to the administrator, at any time, may apply to the court for an order terminating the rehabilitation proceedings and permitting the provider to resume possession of the provider's property and the conduct of the provider's business.

(b) The court shall not issue the order requested pursuant to subdivision (a) unless, after a full hearing, the court has determined that the purposes of the proceeding have been fully and successfully accomplished and that the continuing care retirement community can be returned to the provider's management without further jeopardy to the residents of the continuing care retirement community, creditors, owners of the continuing care retirement community, and to the public.

(c) Before issuing any order terminating the rehabilitation proceeding the court shall consider a full report and accounting by the administrator regarding the provider's affairs, including the conduct of the provider's officers, employees, and business during the rehabilitation and the provider's current financial condition.

(d) Upon issuance of an order terminating the rehabilitation, the department shall reinstate the provisional certificate of authority or certificate of authority. The department may condition, suspend, or revoke the reinstated certificate only upon a change in the conditions existing at the time of the order or upon the discovery of facts which the department determines would have resulted in a denial of the request for an order terminating the rehabilitation had the court been aware of these facts.

SEC. 76. Section 1793.60 of the Health and Safety Code is amended to read:

1793.60. (a) If at any time the department determines that further efforts to rehabilitate the provider would not be in the best interest of the residents or prospective residents, or would not be economically feasible, the department may, with the approval of the Continuing Care Advisory Committee, apply to the court for an order of liquidation and dissolution or may apply for other appropriate relief for dissolving the property and bringing to conclusion its business affairs.

(b) Upon issuance of an order directing the liquidation or dissolution of the provider, the department shall revoke the provider's provisional certificate of authority or certificate of authority.

SEC. 77. Section 1793.62 of the Health and Safety Code is amended to read:

1793.62. (a) The department, administrator, or any interested person, upon due notice to the parties, may petition the court for an order terminating the rehabilitation proceedings when the rehabilitation efforts have not been successful, the continuing care retirement community has been sold at foreclosure sale, the provider

has been declared bankrupt, or the provider has otherwise been shown to be unable to perform its obligations under the continuing care contracts.

(b) The court shall not issue the order requested pursuant to subdivision (a) unless all of the following have occurred:

(1) There has been a full hearing and the court has determined that the provider is unable to perform its contractual obligations.

(2) The administrator has given the court a full and complete report and financial accounting signed by the administrator as being a full and complete report and accounting.

(3) The court has determined that the residents of the continuing care retirement community have been protected to the extent possible and has made such orders in this regard as the court deems proper.

SEC. 78. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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